HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

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JUNE | 1958

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G. M. MARSHALL—Publisher

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Published by HOSPITAL TOPICS, INC., 30 West Washington St., Chicago 2, Ill. Telephone: DEarborn 2-5148. Eastern Sales Office: 7 W. 44th St., New York City. Telephone OXford 7-5262. Subscription rates: one year, $3.50; three years, $8.00; single copy, 50 cents. Canadian and foreign subscriptions: one year, $4.50; three years, $10.00; single copy, 65 cents. A monthly publication. Entered as second class matter at the Post Office, Chicago, Ill.

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PERSONALITY OF THE MONTH

TOPICS departs this month from its usual procedure of featuring a hospital administrator on its cover, in order to honor a surgeon who has contributed much to the hospital field.

He is Gunnar Gundersen, M.D., LaCrosse, Wis., who this month takes office as 112th president of the American Medical Association.

Dr. Gundersen, born in LaCrosse on April 6, 1897, began the practice of medicine in 1922. He now operates the Gundersen Clinic in LaCrosse, together with his brothers, Sigurd B., Alf H., and Thorolf E., all physicians.

Dr. Gundersen's keen interest in hospital affairs and in maintaining high standards of hospital service led to his election as the first chairman of the Joint Commission on Accreditation of Hospitals when it was formed in 1951.

He served in that capacity, during the commission's important organizational period, until 1953. Prior to the commission's founding he had been active in the AMA's program for the inspection and registration of hospitals, through his membership on its Council on Medical Education and Hospitals.

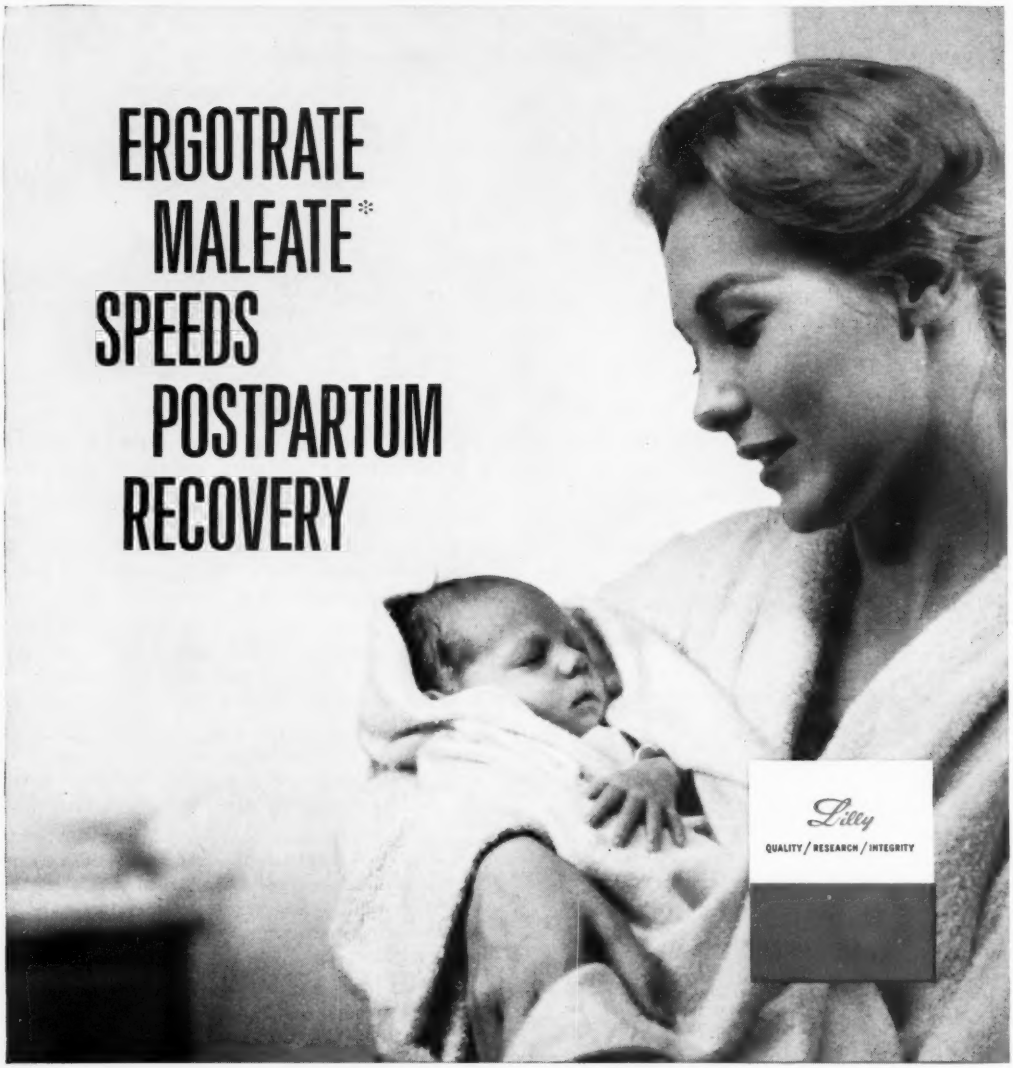
He was first elected to AMA's Board of Trustees in 1948 and became chairman of the board in 1955. He is a member of the Council of the World Medical Association, and of the American Public Health Association.

In his home state, Dr. Gundersen was president of the State Medical Society of Wisconsin in 1941-42, served on several of the society's committees, and was speaker of its House of Delegates for several years. He is also a former member and past president, Wisconsin State Board of Health and a former member of the State Board of Regents of the University of Wisconsin.

Dr. Gundersen did his prep school work in Oslo, Norway, received his B.S. degree at the University of Wisconsin in 1917, and his M.D. degree at Columbia University in 1920.

He is a diplomate of the American Board of Surgery, and a fellow of both the American College of Surgeons and the International College of Surgeons.

Dr. and Mrs. Gundersen have two sons, Gunnar Adolf, a certified radiologist associated with the Gundersen Clinic, Cameron B., an M.D., who is a captain in the Air Force Medical Corps, stationed at McGuire Air Force Base, N.J., and a daughter, Mary, who lives with her attorney husband in Oslo, Norway.



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HOSPITAL Topics
The News Magazine for the Hospital Staff

JUNE, 1958
VOL. 36, NO. 6

Scanning the News

Infectious Hepatitis Is Still a Health Problem

Despite a decrease in reported cases of infectious hepatitis over the last three years, the disease still remains a serious public health problem, according to Metropolitan Life Insurance Co. statisticians.

A report on the disease in the company's December *Statistical Bulletin* stated that from the all-time high of over 50,000 reported cases in 1954, the number dropped to 31,961 in 1955; to 19,234 in 1956; and the estimated figure for 1957 is 15,000.

Just prior to this decline, however, reported cases rose abruptly from less than 17,500 in 1952.

There is some evidence that the sharp rise in incidence largely reflects increasing completeness of reporting, the statisticians said. Nationwide reporting of the disease began in 1952.

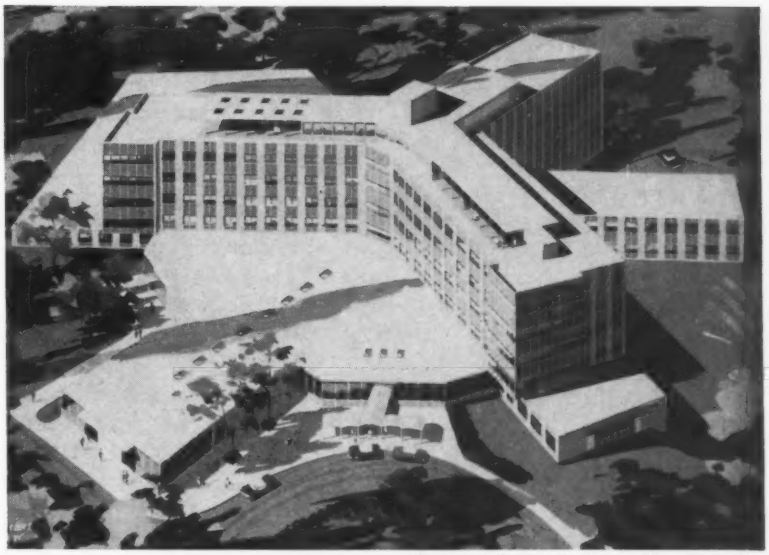
During the four-year period, 1952-1956, number of deaths from the disease varied so little that the death rate remained at 0.5 per 100,000. The 1956 and 1957 mortality figures, when available, are expected to show a decrease.

Male Is Weaker Sex In Fly Population

Male houseflies are a lot more perishable than their feminine counterparts, according to the latest research report.

After studying more than 8,500 common houseflies, Prof. Morris Rockstein and Harry M. Lieberman, of the department of physiology, New York University College of Medicine, found that 50 percent of the females were alive at 30 days of age, while only five percent of the males were still alive then. About half died when approximately 16 days old.

Females live as long as 63 days, the investigators said. Maximum longevity for males is 54 days. The findings were described in the British scientific journal, *Nature*.



Ferrenz & Taylor Architects, New York City

Architect's drawing of Saint Barnabas Medical Center, now under construction in Newark, N. J., illustrates different concept of hospital construction. Devised to facilitate new pattern of patient management which will group patients according to intensity of illness, center will provide three separate patient areas. These include an admission area, on ground floor, where patients enter private or semi-private rooms and remain until tests are completed and diagnosis determined; intensive care areas, on upper floor for medical patients, on ground floor, with operating rooms and recovery room, for surgical patients; and a convalescent area on upper floor. Also on ground floor will be treatment rooms, laboratories, diagnostic facilities.

Baby's First Breath Recorded by Scientists

What may be the first complete scientific record of a baby's first breath has been obtained by American and Swedish scientists.

The research was carried out by Forrest H. Adams, M.D., University of California Medical School, Los Angeles, in collaboration with Dr. Petter Karlberg and Dr. John Lind, Wenner Gren Laboratory, Stockholm.

They took recordings of pressures within the infant's chest during and after delivery, and rapid serial x-rays of the lungs before and during the first few breaths.

Their findings suggest that a sudden expansion of lung capillaries may assist in the lung expansion associated with the first breath.

The expansion is thought to be related to changes occurring when blood flow through the umbilical cord is suddenly shut off. In general, they found no chest recoil in the baby immediately following delivery, which had been thought by some to aid lung expansion.

News Briefs at Press Time

EASING OF MONEY MARKET SEEN IN NEXT SEVERAL MONTHS

Our Washington correspondent predicts easing of the money market, so that interest rates will probably drop within the next several months.

Rates for hospitals are now approximately 5¼ to 5½ percent in many cases.

SENATE PASSES MUNICIPAL LOAN BILL; RUMOR PRESIDENT MAY VETO

Municipal loan bill has been passed by the Senate, after being amended on the floor to make voluntary hospitals as well as municipally-owned facilities eligible for low-interest loans for construction.

Washington rumor has it that the House will also pass the legislation but that the President will veto it. However, the Housing and Home Finance Agency and the PHS are having meetings to plan administration of the program if it becomes law.

SENATE MAY O.K. $210 MILLION FOR H.-B.; REVISIONS PROPOSED FOR EXTENSION

Approval by Senate of $210 million Hill-Burton budget for coming year seems a strong possibility at present time.

Meanwhile, early hearings on extension of Hill-Burton, which expires July 1, 1959, indicate:

—Desire by hospitals and states for more flexibility in determining eligible projects, and by states for greater freedom in transferring funds between categories.

—Pressure for nonsegregation requirement (instead of option of separate facilities).

—Desire for provisions for funds that can be used for rehabilitation of urban hospitals.

Proponents of these revisions may not press for their adoption because of fear of jeopardizing extension.

AHA ASKS $1.5 MILLION FOR DRIVE ON STAPH INFECTIONS

AHA has urged Senate Appropriations Subcommittee to allocate an additional $1.5 million to PHS for the drive against hospital-acquired staphylococcal infections—$1 million for research by the National Institute of Allergy and Infectious Diseases, and $500,000 to PHS Communicable Disease Center in Atlanta for additional support to state laboratories and for field studies and control activities.

PHS, meanwhile, has distributed to all its hospitals recommendations for an interim control program. Recommendations include cultures of personnel in critical areas, periodic checks on fomites, weekly reports by the bacteriology laboratory on all staphylococcal infections among patients and staff, establishment of an infections committee, and measures for sanitation and asepsis.

LEGISLATION INTRODUCED FOR CHANGE IN HOUSING LOAN REGULATIONS

Legislation has been introduced to change present regulations for loans for construction under the College Housing Program—from direct loans by the Federal government at three percent interest to guaranteed loans, such as those for housing for veterans, at 4¾ percent. This proposal has administration backing.

Hospitals operating nursing schools and intern programs are eligible under this program for loans for construction of student residence facilities. A $500,000 loan was recently approved for construction of dormitory for student nurses at Hillcrest Medical Center, Tulsa, Okla.

BRIEF BRIEFS

The five polio vaccine manufacturers, charged with price conspiracy in sales of vaccine to governmental agencies, immediately issued sharp denials. Eli Lilly and Co., in newspaper advertisement, pointed out it has voluntarily reduced price of its vaccine five different times —and has given a discount of 52½ percent from list price on all vaccine sold to governmental agencies . . . Maj. Gen. Paul I. Robinson, head of Medicare program since its establishment in December, 1956, is retiring from Army September 1, on completion of 30 years' service, to become co-ordinator of medical relations for Metropolitan Life Insurance Co.

Gordon M. Marshall

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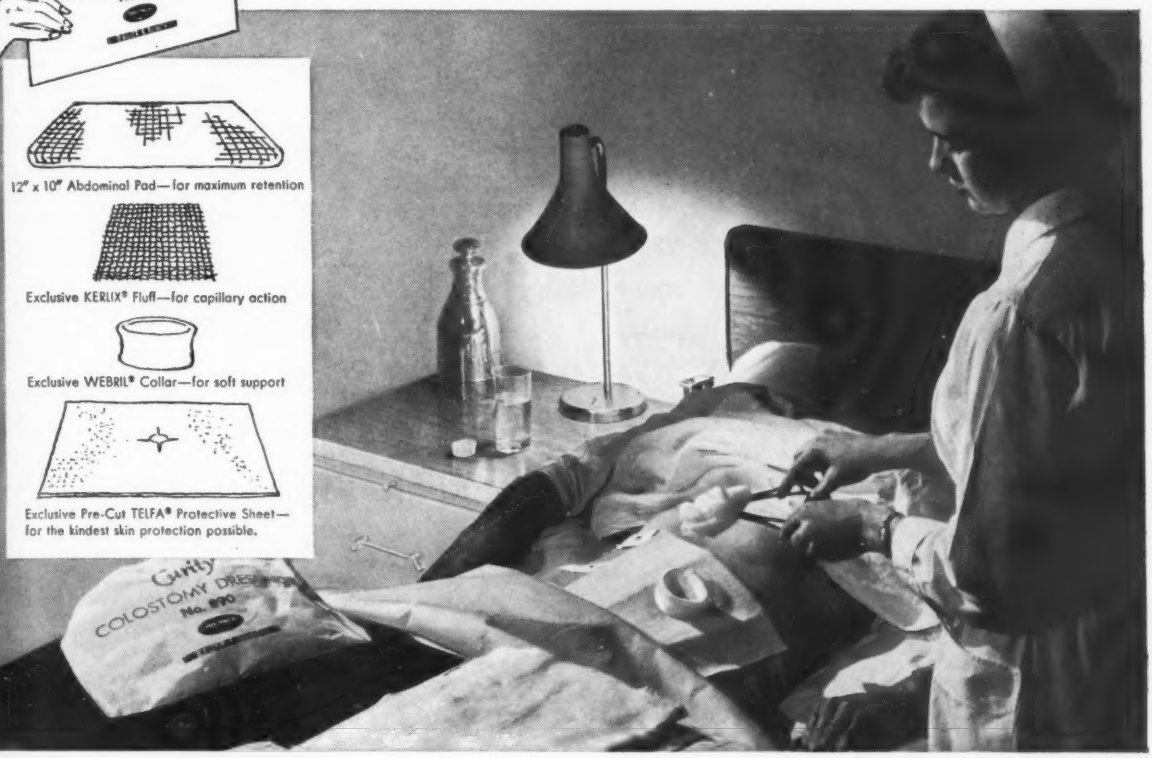
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Calendar of Meetings

JUNE

2- 5 American Hospital Association Institute, Hospital Dental Service, Edgewater Beach Hotel, Chicago

2- 6 American Hospital Association Institute, Dietary Department Administration, Sheraton-McAlpin Hotel, New York City

4- 6 American Hospital Association, Hospital Organization Planning Workshop, Hotel Roanoke, Roanoke, Va.

9-11 American Hospital Association Institute, Administrators' Secretaries, Villa Hotel, San Mateo, Calif.

9-13 American Nurses Association, Convention Hall, Atlantic City, N. J.

10-11 Maine Hospital Association, Samoset Hotel, Rockland

11 Connecticut Hospital Association, Berlin Light and Power Co., Berlin

11-13 North Carolina Hospital Association, Mayview Manor, Blowing Rock, N.C.

15-20 American Physical Therapy Association, Olympic Hotel, Seattle

16-17 National Conference on Labor Health Services, American Labor Health Association, Mayflower Hotel, Washington, D.C.

16-18 Michigan Hospital Association, Grand Hotel, Mackinac Island

16-19 American Hospital Association Institute, Hospital Public Relations, Claremont Hotel, Berkeley, Calif.

16-19 American Society of Medical Technologists, Municipal Auditorium, Milwaukee

16-20 American Hospital Association Institute, Hospital Pharmacy, Temple University, Philadelphia

18-22 American College of Chest Physicians, Fairmont Hotel, San Francisco

23-27 American Medical Association, Plaza Exhibit Hall, San Francisco

23-26 Catholic Hospital Association, Atlantic City, N. J.

25-27 American Hospital Association Institute, Directors of Hospital Volunteers, Bellerive Hotel, Kansas City, Mo.

25-27 Comite des Hopitaux du Quebec, Montreal Show Mart, Montreal

JULY

1- 3 American Hospital Association Institute, Hospital Law, Cosmopolitan Hotel, Denver

1-15 International College of Surgeons, Eastern Regional Meeting, Equinox House, Manchester, Vt.

13-18 American Association of Hospital Accountants, Annual Institute on Hospital Accounting and Finance, Indiana University School of Business, Bloomington

14-18 American Hospital Association Institute, Hospital Purchasing, Michigan State University, East Lansing

28-August 1 American Hospital Association Institute, Hospital Pharmacy, University of Chicago, Chicago

AUGUST

4- 8 American Osteopathic Hospital Association, Medical Record Librarians Training School, University of Colorado, Boulder

15-20 World Medical Association, Copenhagen, Denmark

16-18 American College of Hospital Administrators, Annual Meeting, International Amphitheatre, Convocation, Orchestra Hall, Chicago

(Continued on page 12)

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CALENDAR

(Continued from page 10)

18-21 American Hospital Association, International Amphitheatre, Chicago

24-29 American Congress of Physical Medicine and Rehabilitation, Philadelphia

SEPTEMBER

7-11 American Surgical Trade Association, Shoreham Hotel, Washington, D.C.

8-12 AHA Institute, Dietary Department Administration, Bellerive Hotel, Kansas City, Mo.

15-16 Montana Hospital Association, Havre

15-17 AHA Institute, Disaster Planning, Adolphus Hotel, Dallas, Tex.

18-19 American Osteopathic Hospital Association, Northwest Institute, Multnomah Hotel, Portland, Ore.

22-25 AHA Institute, Evening and Night Nursing Service Administration, Sheraton-Lincoln Hotel, Indianapolis, Ind.

25-26 AHA Institute, Hospital Insurance, Capitol House, Baton Rouge, La.

28-Oct. 1 American Fracture Association, Oklahoma City, Okla.

29-Oct. 2 AHA Institute, Operating Room Administration, Sheraton-McAlpin Hotel, N. Y.

29-Oct. 2 AHA Institute, Medical-Social Workers, Hotel Radisson, Minneapolis, Minnesota

OCTOBER

6-10 American College of Surgeons, Conrad Hilton Hotel, Chicago

8- 9 Indiana Hospital Association, Indiana University Medical Center Campus, Indianapolis

12-17 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

13-16 American Association of Medical Record Librarians, Statler Hotel, Boston

15-16 Washington State Hospital Association, Winthrop Hotel, Tacoma

15-17 Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask., Canada

16-18 West Virginia Hospital Association, Daniel Boone Hotel, Charleston

20-21 Idaho Hospital Association, Elks Temple, Boise

20-23 American Academy of Pediatrics, Palmer House, Chicago

21-23 American Dietetic Association, Trade and Convention Center, Philadelphia

21-23 Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alb., Canada

21-24 American Society of Anesthesiologists, Penn Sheraton Hotel, Pittsburgh

22-24 California Hospital Association, Biltmore & Miramar Hotels, Santa Barbara

23-24 Mississippi Hospital Association, Hotel Heidelberg, Jackson

23-24 Nebraska Hospital Association, Omaha

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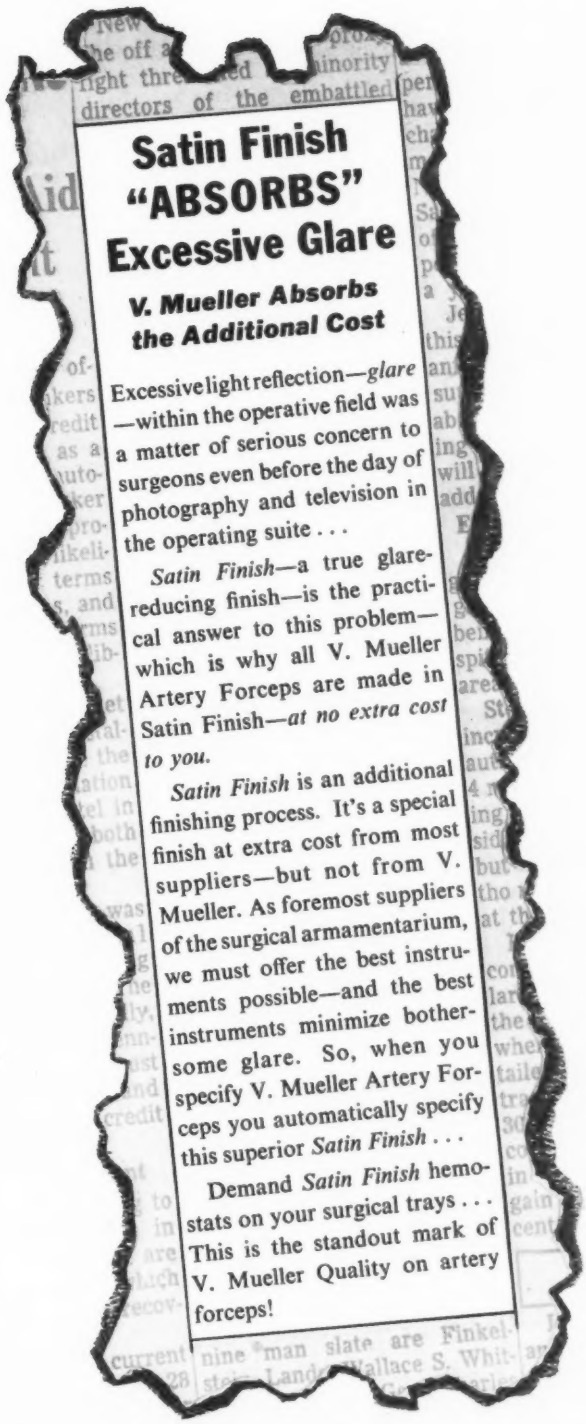
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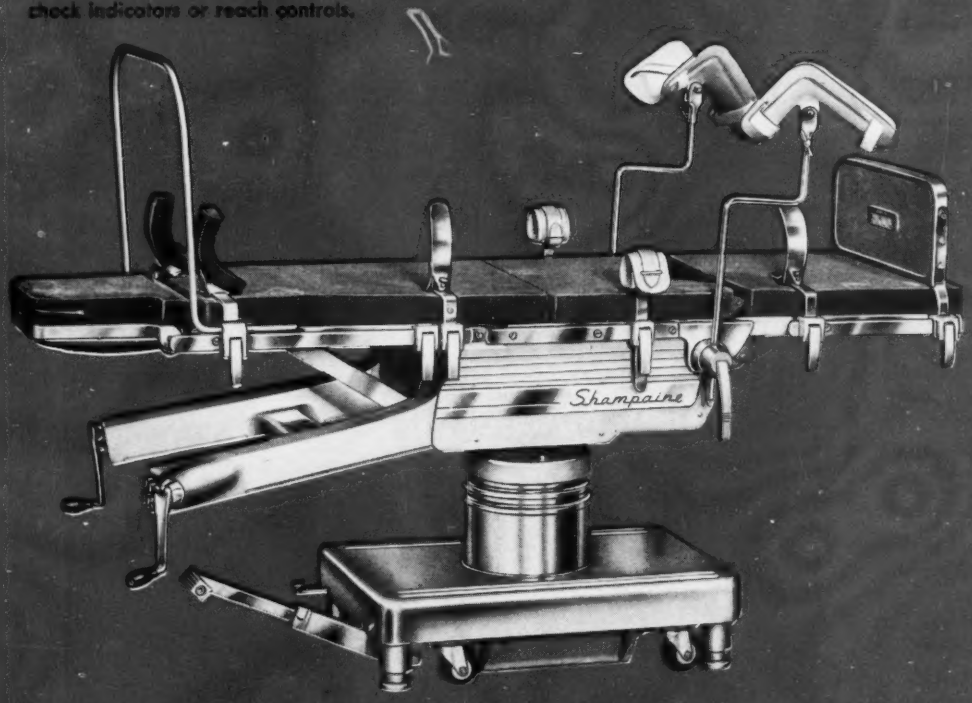

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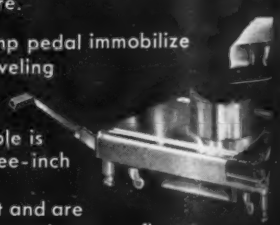

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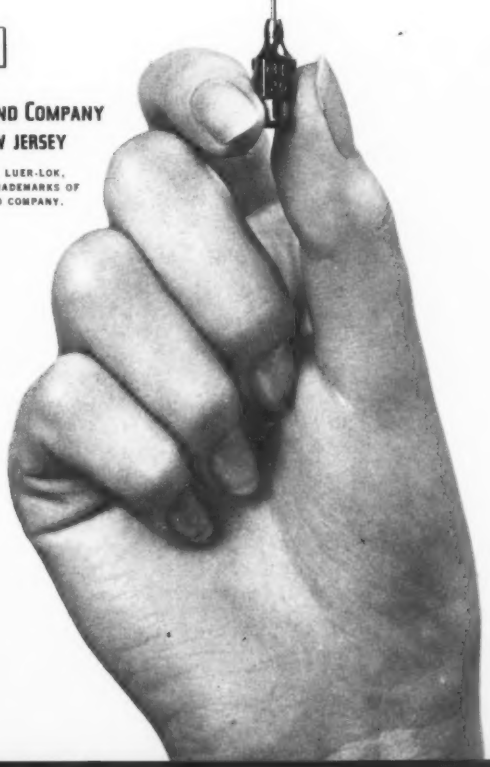

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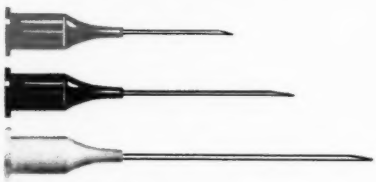

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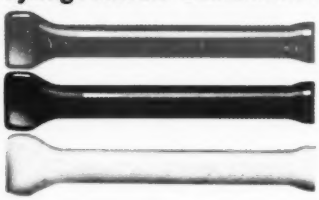

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55458

Effective Use of Hospital Personnel Subject of Tri-State Panels

8,400 Registrants at 28th Annual Meeting Highest in Assembly's History

Accreditation, Better Care Synonymous; Four Major Problems Listed

Staphylococcal Infections Called Administrative, Medical, and Nursing Problem

Accreditation and patient care are synonymous. Thus, hospitals should strive for better patient care—not just accreditation.

At the present time, there are four major problems in accreditation:

1. The attempt to standardize the hospital's department of medicine, which cares for 40 percent of patients. Probably, the documented evidence of the chart is the best method of analyzing medical care.

2. The possibility that clean surgical or gynecological cases could be admitted to the obstetrical floor. This might be allowed with certain controls. Rooms and nursing care would have to be segregated if this combining were done.

3. Staphylococcal infections (hospital-acquired). This is an administrative, nursing, and medical problem. The importance of following basic technics must be emphasized. Two things that must be done are to determine which of the personnel are carriers and to revamp the program for cleaning equipment, checking air-conditioners, and other possible danger points from which infection might be transmitted.

4. Lawsuits involving hospitals and doctors. Hospital cases now account for 67 percent of all malpractice suits.—*Kenneth Babcock, M.D.*, executive director, Joint Commission on Accreditation of Hospitals, Chicago.

Reports Good Results in Pilot Study On Geriatric Rehabilitation Unit

Some Patients Believed 'Hopeless' Cases Restored to Community

Initial results in the first six months of a pilot study on a geriatric rehabilitation unit at Michael Reese Hospital were encouraging enough to warrant continuation and even expansion of the program.

The project was established in March, 1957, in cooperation with the Illinois Public Aid Commission and the Cook County Department of Welfare. Its purpose was to investigate the possibilities of decreasing the institutionalization of chronically ill aged patients by bringing to bear on their illnesses the knowledge and skills present in an acute general hospital.

A special four-bed unit was set up within the division of medicine, under the direct supervision of the full-time director of the department of physical medicine and rehabilitation. Personnel assigned to the unit were a full-time research fellow supported by a PHS research grant, an internist, a psychiatrist, and a social worker from one of the hospital's other services. In addition, all other services and facilities of the entire hospital were placed at the disposal of the geriatric rehabilitation unit.

Before patients were accepted for admission, they were first screened by social workers of the Cook County Department of Welfare, then by the research fellow, and were finally reviewed and evaluated by the geriatric rehabilitation service staff. We learned very early that proper psychological motivation was one of the most important criteria for successful rehabilitation. Much careful study is required to evaluate this factor accurately.

In the first six months of operation, 43 patients previously considered "hopeless cases" were screened. Of these, 23, or 54 percent, were found acceptable for admission. They included persons with amputations, fractures, diabetes, arthritis, cardiac conditions, and other ailments.

Seventeen of the 23 had been hospitalized, and six were awaiting admission at the time the report was compiled. At the end of the first six-month period, 13 of the 17 had been discharged, leaving four still in the hospital. Of the 13, nine, or 69 percent, were restored to the community; one had been transferred to Rest Haven for long-term rehabilitation, and three were returned to nursing homes.

Duration of hospitalization varied from 11 to 81 days, with an average of 41 days. In some instances excessively prolonged hospitalization was due to difficulty in finding suitable living accommodations for patients who were otherwise ready for discharge.

Ages of screened patients ranged from 65 to 86, with an average of over 76. Many had spent prolonged periods of neglect and inactivity in nursing homes, resulting in physical, mental, and psychological deterioration.

We are convinced that had screening been made available to these patients earlier in their illnesses, results would have been even more favorable.—*Morris H. Kreeger, M.D.*, director, Michael Reese Hospital, Chicago.

(Continued on next page)

"Building Good Will Inside the Hospital" was discussed by this panel: (front row, l. to r.) Jane Wheeler Warren, director of public relations, Presbyterian - St. Luke's Hospital, Chicago; Helen W. Dunn, director of nursing, Research and Educational Hospitals, University of Illinois, Chicago; Emily Withrow Stebbins, director of public relations, Evanston (Ill.) Hospital Association; and (back row, l. to r.) Delbert Price, board of directors, Tri-State Hospital Assembly, who brought greetings from the assembly; Fred Bjorling, director of personnel, University of Chicago; John M. Danielson, administrator, Evanston (Ill.) Hospital Association.

Work Simplification Is Organized Approach to Job Problems

Demands Substitution of Positive Ideas for Negative Ideas

Work simplification is an organized approach to find an easier way of performing a task. To those participating in a well-organized work simplification program, it becomes a way of thinking.

The program follows seven steps: (1) selecting the task to improve; (2) getting the facts and making a chart; (3) consulting all those concerned; (4) challenging every detail, listing possibilities; (5) developing the easier method; (6) installing the easier method, and (7) following through.

Work simplification as a philosophy makes use of the following factors common to group activities: (1) it's fun to participate in group activity; (2) it's natural for most people to want to improve; unless inhibited, they will try to improve if given the chance; (3) we learn from others—no one of us is as smart as all of us; (4) it's not *what* you do but the *way* you do it; (5) there is always an easier way; (6) it's not what you say but how you say it; you can tell people, sell them, consult them (the work simplification philosophy is based on the latter).

Management indoctrination is the first phase of the work simplification program. The second phase is educational, consisting of regular group discussion sessions. In the third phase, employees graduate into the application of work simplification principles.

If the program is to be effective, employees must free their minds of negative ideas such as "It will never work," "We've tried it before," "We've always done it this way."

Positive ideas must be substituted, such as "Why wait?" "There must be an easier way," "That is good thinking," "We're not too busy to be efficient." —*Floyd W. Simerson,* assistant to the vice-president in charge of factories, Sears, Roebuck and Co.

B. Cullen Burris, M.D., clinical instructor, department of psychiatry, Northwestern University Medical School, Chicago, speaks on "Supervisory Problems in Office Interpersonal Relations," at Medical Record Library Service conference.

Supervisor Must Be Able to Appraise Himself as Well as Subordinates

Workers Classify Supervisors By Bad Habits, Not Good Ones

The supervisor has become the key figure in the productive effort of an organization. This responsibility places an increased demand on him for a better understanding of the individuals who work over him, with him, and under him. He must also be able to make a realistic appraisal of himself.

He must realize that individuals think differently, act differently, feel differently. Factors which they have in common are the need to belong to a group, the need to be important and receive recognition, the need for security, and a basic resistance to change.

Employees tend to classify their supervisors according to bad habits rather than good ones. They may lump them into one of five commonly accepted groups.

(1) The "Simon Legree" supervisor—a slave-driver who pushes the people under him as long and as hard as possible, with little or no consideration for their needs, likes, or dislikes.

(2) The "namby-pamby" supervisor—one who suffers from his own insecurity, who is uncertain of himself, his job, his ability to handle people. As a result, he constantly yields to pressures as they present themselves, in a bid for popularity.

(3) The "politician"—the supervisor who cannot be trusted. He changes his approach to suit his convenience, often pitting one employee against the other. He is adept at "passing the buck," at finding someone whom he can blame for his own mistakes.

(4) The "do-it-myself" supervisor—one who is confused about the requirements of a supervisory position; often is a skilled worker but is unaware that his job as a supervisor is to get other people to work. He is happier using his hands than his head.

(5) The "I'm Number One" supervisor—one whose normal desire for recognition is exaggerated so as to become a disease. He demands to be consulted on every detail. Ideas and efforts of those under him are deprecated and rejected. He keeps workers and visitors waiting in order to make himself feel more important.—*B. Cullen Burris, M.D.,* clinical instructor, department of psychiatry, Northwestern University medical school, Chicago.

Above, left: Edward J. Sparling, Ph.D. (center), president, Roosevelt University, Chicago, was guest speaker at luncheon sponsored by American College of Hospital Administrators. Here he talks with Frank S. Groner (l.), Memphis, Tenn., ACHA president, who also spoke at meeting, and Ray E. Brown, superintendent, University of Chicago Clinics, a regent of ACHA, who presided. Above, right: Participants in the Tri-State Hospital Assembly annual luncheon meeting are: (l. to r.) Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville, Ind., Tri-State executive director; Mrs. Grace O. Hahn, assistant administrator, Protestant Deaconess Hospital, Tri-State associate director; A. C. Kerlikowske, M.D., Ann Arbor, Mich., director, University of Michigan Hospital, Tri-State president; and Walter H. Theobald, M.D., president, Medical Center Commission, Chicago, a speaker.

Hypnosis Valuable Adjunct In Physical Therapy

Can Be Used to Take Advantage Of Reservoir of Strength

Hypnosis is a valuable adjunct, another arrow in the physical therapist's quiver.

If used wisely and judiciously, it can potentiate other forms of physical therapy. It is not a panacea except for the disability produced by hysteria and similar conditions.

As long as one hemisphere of the brain is still functioning well, there is no fixation of joints or contracture of muscles, and the spastic reflex mechanisms are intact in the paralyzed part, the normal "spastic" brain can be taught to regulate the lower centers of both sides in a greatly improved manner.

Although nothing new has been added to function at the cortical level and no regeneration of lost brain or cord cells is possible, the patient feels improved. A change of morale from hopeless to hopeful usually follows.

Any danger to morale lies in the possibility that the patient may want too much and become discouraged and disappointed that full recovery is not possible.

A vast reservoir of strength can be tapped by hypnosis, because it mobilizes the adaptive responses of the body. It would be useful in polio, multiple sclerosis, and spastic patients.

Since the polio virus destroys anterior horn cells and thus interrupts communication to the associated muscle fibers, and since regeneration of the damaged cells is not possible, the objective of rehabilitation therapy in postacute polio is to hypertrophy the remaining innervated muscle fibers to the maximum level attainable.

The most startling example of unusual strength and muscle control is the unsupported suspension of a human subject between two chairs while hypnotized. If such ability exists within the human body, it should somehow be possible to utilize it for the benefit of the individual.

Whether the method be through posthypnotic suggestion or through some yet undefined learning process, the potential benefit to the physically disabled is incalculable.

Two possibilities come to mind. First, if the patient can be made to exert himself more, whether while under hypnosis or as a result of posthypnotic suggestion, a higher level of hypertrophy might be achieved. Secondly, if the unusual strength and control available in hypnosis were made available to a conscious desire, the improved movement of affected limbs, previously nonfunctional, might again become a reality.

Of course, there must be residual muscle fibers with innervation to effect any strengthening.—*William S. Kroger, M.D.*, associate professor, Chicago Medical School, and president-elect, Academy of Psychosomatic Medicine.

Illinois Changes Structure of Narcotic Regulations

State to Issue Prescription Blanks

New regulations in Illinois now classify narcotics into three categories and determine the method of dispensing them. These regulations went into effect June 1.

Class A narcotics are designated as those which are addicting, such as morphine and Demerol. Class B drugs are those which are narcotic by definition but not by pharmacological action. Class X includes those which are exempt narcotic preparations and are sold over the counter without a prescription.

Drugs which are classified as "A" must be dispensed by prescription only and on special prescription blanks provided to the physician by the state. They are

(Continued on next page)

Recipients of Tri-State's awards for outstanding service to hospitals are pictured here, together with presidents of their state hospital associations. Above, left: Ralph M. Hueston (l.), superintendent, Chicago Wesley Memorial Hospital, with the Rev. John Weishar, director of Catholic hospitals, Diocese of Peoria, Ill., president, Illinois Hospital Association.

Above, center: John W. Rankin (l.), director, Milwaukee County (Wis.) Institutions and Departments, and president, Wisconsin Hospital Association, hands pin symbolizing award to the Rev. A. H. Schmeuzer, administrator, Evangelical Deaconess Hospital, Milwaukee.

Above, right: Olive M. Murphy, R.N. (l.), administrator, Batholomew County Hospital, Columbus, Ind., presents Indiana's award to Martha O'Malley, M.D., director, division of hospital and institutional services, Indiana State Board of Health, Indianapolis.

Left: Ralph C. Hutchins (l.), administrator, Gratiot Community Hospital, Alma, Mich., congratulates Emory W. Morris, president and general director, W. K. Kellogg Foundation, Battle Creek, Mich.

written in duplicate and one copy is retained by the hospital pharmacy.

Class B drugs may be prescribed on ordinary prescription blanks.

Hospitals will be required to keep records to show what was bought and daily records to show how it was dispensed.—*Samuel Shkolnik, LL.M.*, lecturer of pharmaceutical jurisprudence, University of Illinois, College of Pharmacy, Chicago, and legal counsel, Illinois Pharmaceutical Association.

Purchasing Agent's Responsibility In Planning for Disaster

Employee Training, Attitude More Important Than Material Things on Hand

The purchasing agent making plans for disaster purchasing must see that he has adequate stock on hand at all times, that he can get delivery on short notice, that he has the ability to replenish his stock quickly, and that proper plans have been made if there is a curtailment in communications.

A simple plan is usually the best. Normal inventory takes care of ordinary demands for about 30 days, so that stockpiling really is not wise. A few special items, such as disaster tags and paper bags for valuables, should be kept in readiness.

When new equipment has been purchased, it may be advisable to keep the old equipment on hand rather than trade it in. Some hospitals keep all old equipment in an emergency warehouse. This is stockpiling but not in a way that ties up money.

What is more important than the material things on hand is employee training and attitude. One of the biggest problems is keeping up the interest of the employee in the program. It is advisable not to get all the personnel active at one time. If groups are staggered, their interest is not diminished so quickly. In this way, all new employees will become part of the disaster program.— Panel members: *J. R. Knight*, purchasing agent, University of Illinois, Chicago; *Robert Jones*, administrator, Waukesha (Wis.) Memorial Hospital; *David Everhart*, assistant director, Henry Ford Hospital, Detroit.

Everyone Blamed for Poor Co-operation In Routine Admission X-Ray Program

Simplified Records, Procedures, Evaluation, Solving of Budget Problem Needed

Administrators, radiologists, the medical staff, patients, and public health departments are all equally at fault for poor co-operation in x-ray screening programs at the time of the patient's admission to the hospital.

Many administrators, unfortunately, fail to insist on admission screening, do not try to sell employees on the value of the program, worry that this type of program may increase hospital costs, and think of it

Above, left: Photographed between sessions at the Tri-State Assembly are: (l. to r.) Alene Dankse, R.N., head nurse, West Side VA Hospital, Chicago; Iris Hill, R.N., supervisor, central service, University of Illinois Research and Educational Hospitals, Chicago; and Esther M. Swanson, R.N., supervisor of central service, Hines (Ill.) VA Hospital.

Above, right: Mary Josephine Williams (l.), patients' librarian, Riley Hospital, Indianapolis, explains library services in a children's hospital to Rose E. Burket (center), hospital librarian, Benton Harbor (Mich.) Hospital, and Katharine T. Harker, patients' librarian, Presbyterian-St. Luke's Hospital, Chicago. The three spoke at a conference on library service for patients.

only as a tuberculosis case-finding tool. Actually, admission x-rays are becoming more valuable in finding other chest abnormalities.

Radiologists, too, often do not see the value of such a program, nor are they interested in doing any follow-up of suspect cases. They question the value of a screening program because they feel it gives the patient a false sense of security, when actually a small film does not show enough detail.

Medical staff members fail to explain the radiation hazard to patients, fail to do proper follow-up, feel that the radiologist has a tendency to over-read the film, and sometimes suspect that the x-ray examination is only a way to get more money from the patient.

Patients complain about the cost of the film, object to this delay at the time of admission, and are overly worried about the radiation hazard.

If the hospital can develop simplified records and procedures, solve the budget problem, and establish an evaluation committee, such a screening program would be invaluable. It is hoped that Blue Cross and other insurance companies will, at some time, see fit to absorb the cost.—*Victor Jonak*, hospital administrator consultant, Department of Health, Lansing, Mich.

Radiation Scare Makes It Difficult To Promote X-Ray Screening Program

Administrator Should Assure Public Of Safety of Examinations

The wide publicity given to radiation hazards and the resultant radiation scare has created a problem for the hospital administrator who is trying to screen all incoming patients with chest x-rays. The public has exaggerated all scientific reports and has become increasingly concerned with effects of radiation—especially the genetic effects.

Hospital administrators can help solve this problem by assuring the public of the safety of x-ray examinations. Ignoring the necessity for a screening or diagnostic x-ray may be much more serious than the radiation. It should be emphasized that there is very little radiation hazard with chest x-rays.

It is recommended that administrators and radiologists explain the facts to patients—especially to the older ones who need not worry about genetic effects. The administration should also provide for proper supervision of equipment, making sure that it is in good working order at all times. It should check the experience of technicians, see that fast film is being used, and warn technicians to watch the direction of the beam so that it does not affect the gonads.

Administrators would also do well to familiarize themselves with the statements issued by the Public Health Service and the National Tuberculosis Association.—*Warren Furey*, professor of radiology, Stritch School of Medicine, Loyola University, Chicago.

Major O.B. Department Problem: What to Do with Unused Bed

Chicago Hospital Reports Success In Putting 'Clean' Gyn Cases on Unit

The number one obstetrical department problem today probably is what to do about unused beds in the unit. For the last two years pilot studies have been under way at Henrotin Hospital and other Chicago hospitals to determine whether clean, non-infected gynecological patients can safely be put on the obstetrical floor.

Our experiences doing this at Henrotin have been very good. We have had no infections; the nursery has had no contagious cases. Success of such a plan, of course, depends on the co-operation of the doctors who admit cases. Supervision depends to a great extent on the superintendent of nurses and the chief obstetrical nurse, to pick up any evidence of infection as soon as it occurs. The administrator should keep an eye open for patients who might be transferred.

(Continued on next page)

A second problem is proper supervision of the patient once she is in the hospital. The hospital has a responsibility to provide a qualified staff and the best possible conditions and equipment for delivery of the child.

There are many pros and cons on induction of labor with intravenous pitocin, but I believe the method is here to stay, and we should organize our hospitals to make sure that the patient receives the necessary supervision. A well-trained person must be with the patient. I think that nurses can be trained for such observation.

Staphylococcal infections constitute a third major problem. There has been an increase in breast infections in patients who have been released from the hospital. We must go back to fundamentals—washing hands, careful scrubbing up before delivery, following proper technics in the delivery room and the nursery. With proper technics, I think we can prevent these infections.

A fourth problem, I feel, is that sometimes our patients expect too much in the way of tender, loving care. I don't know the answer to this problem, but I think we can go a long way toward solving it if we all try to do just a little extra for the patient. —*John R. Wolff, M.D.*, associate professor of obstetrics and gynecology, University of Illinois College of Medicine, and chairman, obstetrics and gynecology department, Henrotin Hospital, Chicago.

Improving Patient Care Requires Theory, Plan, Implementation

Needs, Goals Must Be Outlined For Participating Personnel

To improve patient care, an approach must be found which will help physicians and hospital personnel come to basic understanding and agreement on needs and goals.

Fundamental and dramatic changes have created a complex, interdependent relationship between physician and hospital personnel in providing patient care. Previously this relationship was direct and simple. Face-to-face contact was adequate to provide a plan of care, evaluate the results, and make adjustments as indicated.

The tremendous increase in number and type of persons involved in patient care, number of patients to be cared for, health needs of patients, and methods of caring for them has made simple, face-to-face contact impossible.

Patient care must be brought into harmony with the actual needs of the patient. These include diagnosis, treatment, rehabilitation, prevention of disease, and personal care. The goals of patient care, while varying with the condition of the patient, include: (1) curing or alleviating the effects of disease or injuries; (2) promoting a positive state of health; and (3) restoring the patient to effective living in accord with his disabilities as well as his abilities and capacities.

While these needs and goals cover essentially medical functions, aspects of them are carried out by hospital personnel. Patient care should not be divided into two separate parts, one part medical care and the other hospital care. The two must form a closely united whole.

Accomplishing this is the joint obligation of the medical and hospital professions. A plan, or set of standards, must be provided for all persons participating in total patient care to provide a basis for understanding.

Steps in developing a patient care improvement plan and staff retraining program include: (a) defining health needs of patients served; (b) providing care which actually and effectively meets the patient's needs; (c) securing personnel with "know-how" and encouraging development of existing staff; (d) providing conditions which make it possible for personnel to render good care.

Patient care programs should provide for the following: (1) number and types of patients to be served; (2) a general plan of care for major categories, including goals, plan of care, and role of each discipline; (3) a simple and effective means of determining and planning care needs of individual patients; (4) standards for placement of patients according to their needs; (5) standards for staffing, based on patient care needs and placement.

Since personnel are the key factors in patient care, considerable effort must be spent to determine the training and experience required and the conditions of work necessary to enable them to give care effectively. It is especially important that provisions be made for close working together of personnel of all divisions involved in patient care.—*Martha O'Malley, M.D.*, director, division of hospital and institutional services, Indiana State Board of Health, Indianapolis.

Pilot Study on Ward Tests, Evaluates Methods of Improving Patient Care

As a concrete step toward improving patient care at Indiana University Medical Center, Ward C, Long Hospital, was set up as an experimental unit. Medical and hospital staff on this ward participated in the pilot study, making it possible to centralize the work and to try out recommended changes before applying them to other units of the hospital.

Changes were made gradually after considerable evaluation and trial. The changes and the philosophy behind them were explained to all personnnel, to create an atmosphere of teamwork and group activity. All personnel were encouraged to participate in planning for work improvement and better patient care.

All levels of personnel were encouraged to understand the total care plan for the patient and to participate in it. All personnel heard shift reports, and attended group conferences and patient care conferences. They could attend ward rounds if they wished and were free to see nursing care cards. They were

encouraged to use the medical dictionary on the ward and expand their knowledge in other ways.

Changes in procedure were also instituted. A simplified method of charting was introduced. Alterations were made in such routines as taking temperatures and respiratory rates, to eliminate unnecessary effort. New methods, such as the use of disposable syringes, were studied and evaluated.

The following results have been obtained in this pilot study:

An advancement has been made in improving patient care. The ward has provided a means of solving problems of patient care at the patient care level.

All levels of staff have shown growth of personal potential and improvement in knowledge and skills of patient care. Each person understands his functions and responsibilities better, and co-ordination of total effort has been improved. Morale of the staff is better also.

It has been possible to apply methods tested in the research unit to operation of the entire hospital. Further, the ward has developed into a valuable tool for trying out new improvements and ideas.—*Helen R. Johnson, R.N.*, associate director, nursing services; *Hunter A. Soper, M.D.*, attending physician, medical services; *Edmund J. Shea*, administrator; *Virginia Walker, R.N.*, director, nursing services; *Billie Bond, R.N.*, head nurse, Ward C, Long Hospital; *Richard B. Schnute, M.D.*, resident physician, medical services; *Virginia Folkerth, R.N.*, assistant director, nursing service, Coleman Hospital; *Francisco D. Sabichi*, administrative resident; all of Indiana University Medical Center, Indianapolis; and *Martha O'Malley, M.D.*, director, division of hospital and institutional services, Indiana State Board of Health, Indianapolis.

Things to Consider Before Adopting Selective Menu System

Four Sets of 21-Day Menus Used in Speaker's Hospital

Before adopting the selective menu system, careful planning and consideration are necessary. Kitchen and serving facilities must be studied. Do you have space on your tray lines, steam tables, and food carts for the additional items?

Preparation and storage constituted our greatest difficulty, as our kitchen and service areas are very limited.

Careful consideration of the menu is all-important. A majority of Americans prefer their heaviest meal at night.

Delivery and pick-up of menus, we believe, should be made by a dependable member of the dietary department. If the nursing service performs this job, the dietary department's contact with the patient is lost. At our hospital the job is done by a dietary assistant or dietetic intern.

All menus must be retrieved. Once a patient has selected, he expects to receive what he has chosen.

Above: At conference on front office service, the philosophy of work simplification and means of achieving it was considered by hospital personnel and industrialists. Comprising the panel are: (l. to r.) Floyd Simerson, assistant to the vice-president in charge of factories, Sears, Roebuck and Co., Chicago; William J. Silverman, associate director, Michael Reese Hospital, Chicago, moderator; Bruce Karnes, work simplification engineer, Whirlpool Corp., St. Joseph, Mich.; George Deschambeau, staff methods engineer, Michael Reese Hospital, Chicago; and Donald J. Caseley, M.D., medical director, Research and Educational Hospitals, University of Illinois, Chicago.

Right: Guest speaker at federal hospitals dinner is Fred A. McNamara, Bureau of the Budget, Executive Office of the President, Washington, D. C.

We use four sets of 21-day menus, one group for each of the four seasons. This plan permits use of all seasonal foods. Dinner entrees remain the same throughout. We thus have a built-in cost control, since the entree is the highest-priced single item on any tray. Breakfast, lunch, and other dinner foods vary.

These four same cycles have been in use now for almost two years. Adjustments are made all the time; new items are added and old ones deleted.—*Barbara Lee Awrey*, director of dietetics, Jennings Memorial Hospital, Detroit.

Sound Accounting, Credit Systems Needed to Meet Economic Challenge

Accountant Is Vital Member Of Hospital's Management Team

Financial aspects of hospital management have grown in size and complexity to the point at which the trained accountant is a vital member of the management team.

Any general hospital of 100 beds or more should employ a trained accountant on a full-time basis. The least such a hospital could have in charge of its accounting is a capable bookkeeper. There is not the slightest doubt that a trained accountant saves the hospital more than the difference between his salary and that of a bookkeeper.

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New Officers are (l. to r.): Joseph L. Zem, director, St. Luke's Hospital, San Francisco, re-elected treasurer; Paul S. Bliss, administrator, Vancouver (Wash.) Memorial Hospital, third vice-president; Ralph J. Hromadka, superintendent, Santa Monica (Calif.) Hospital, president; and Wesley G. Lamer, administrator, Physicians and Surgeons Hospital, Portland, Ore., president-elect. Not shown are John H. Zenger, administrator, Utah Valley Hospital, Provo, first vice-president, and Sister Ann Raymond, administrator, St. Vincent's Hospital, Billings, Mont., second vice-president.

Western Registers over 5,100 To Set New Attendance High

Reports of key papers delivered at Association of Western Hospitals meeting in San Francisco April 21-24, begin on opposite page

All Hospitals Should Be Geared To Care of Long-Term Patient

Says Integrated Program Better, Cheaper Than Many Unco-ordinated Services

Whenever we successfully add a hospital facility within a custodial institution in order to perform the necessary function of rehabilitation, we will find that we have added another general hospital to the community. To avoid such an eventuality, and to assure the most efficient and economical level of patient care, all hospitals should be geared to the care of the long-term patient.

Criteria for admission should be based on the need for a hospital bed—not on an artificial compartmentalization of patients according to the anticipated duration of illness.

Use of the general hospital and of the home, together with home medical care to fill any gaps in care, plus the use of substitute homes when necessary, will provide an integrated program that will be better and cheaper in the long run than a multiplicity of unco-ordinated facilities and services in the community.

What can hospital administrators do to further integration and co-ordination of services? An administrator who lives in a community in which the need for medical services has not been studied can take the leadership in forming a group to review the existing facilities and the gaps in service that exist, and to evolve a list of short-term and long-term goals. Since the emphasis is often on completing the study rather than beginning a program, the administrator should also assume at least part of the responsibility for getting something done about the study.—*Mark Berke*, director, Mount Zion Hospital and Medical Center, San Francisco.

Worker Who Pays for Own Coverage Less Likely to Abuse It

Outline's Employer's Wants

If the worker pays for his own medical and hospital care coverage, he is likely to be interested in what he gets for his payments—and less likely to abuse what he gets. On the other hand, if he is compelled to pay for coverage for himself and others at the point of the tax gun, he is certain to demand his share of the "benefits"—and his share soon becomes everything he can think of to ask for.

Premiums of a realistic prepaid group plan can be kept well within the employee's ability to pay, if: (1) employees are told clearly what is and is not covered, and why; (2) there is a direct connection between use and the employee's pocketbook nerve; (3) facts about overuse and abuse are told and demonstrated periodically; and (4) the plan is administered with integrity and watchful care, using the "personal touch" to the highest degree possible.

Some things the employer would like are: a schedule of benefits adequate for the serious cases which could otherwise be catastrophic in cost to the employee; a basic plan which permits prepaying by the group for probable ordinary care; accurately predictable premium or service costs; substantial contributions by the employee to the cost of basic coverage; placement of coverage with carriers or service organizations of long experience and demonstrated ability to pay; actuarial advice free from bias; reduced absenteeism, lower mortality, and reduced morbidity rate.—*John B. Wallis*, secretary and personnel manager, Pacific Lighting Gas Supply Co., Los Angeles.

Says Inquiries into Need for Higher Rates Not Harmful to Blue Cross

Public Gains Knowledge of Operations; Prepared to Pay More Inclusive Coverage

Some persons feel that Blue Cross is being hurt or at least threatened by the public hearings held this year, chiefly on requested rate increases, in about one out of every five states. I do not agree. I believe the public has attained a better knowledge of day-to-day Blue Cross operations.

Hearings and legislative commissions to inquire into various aspects of prepayment mechanisms can only make it clearer that Blue Cross has a unique ability to meet the public's demand for continued health care progress. This ability is the result of the fact that

A group of presidents, snapped at closing session. L. to r.: Donald S. Showman, administrator, Kennedy Deaconess Hospital, Havre, Mont., and past president, Montana Hospital Association; Ralph J. Hromadka, superintendent, Santa Monica (Calif.) Hospital, and new Western president; Sister M. Alma Dolores, administrator, St. Alphonsus Hospital, Boise, Ida., and president, Idaho Hospital Association; and Richard Highsmith, administrator, Samuel Merritt Hospital, Oakland, Calif., and president, California Hospital Association.

every Blue Cross plan is a local plan established to serve the public by providing a means for all members of the community to finance their health care needs.

The public is prepared to pay for a more inclusive health care package. We are developing a complete hospital care contract which will be sold to national accounts and which could be serviced by the Blue Cross plans.

The next five years should see a far higher prevailing standard of benefits among the plans. I visualize that standard including provisions for preventive, diagnostic, and rehabilitation services provided by

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James E. Ludlam (second from left), legal counsel, California Hospital Association, answers questions at end of final session. L. to r.: B. J. Caldwell, administrator, Memorial Hospital of Glendale, Calif.; Mr. Ludlam; John P. Preston, administrator, Inter-Community Hospital, Covina, Calif.; and Ernie H. Stewart, administrator, General Hospital, Eureka, Calif.

hospital outpatient departments, and benefits for long-term illness, convalescent care, home nursing, and the like.

Prepayment plans and hospitals must discourage benefits which raise the total cost of health care to the public, and encourage those benefits which will lower the cost. Wherever a hospital council exists, with influence on public opinion, there is less danger of hospital beds becoming as excessive as the present motor-car inventories.

Controls on marginal or unnecessary use of health services rest primarily with the hospital and the doctor, not the patient.

The communities in which each plan operates will have to be brought into a closer partnership in setting Blue Cross policy and objectives. Most Blue Cross boards have far too little representation of important consumer groups. Hospitals should not have more than one-third of the membership on Blue Cross boards.—*Basil C. MacLean, M.D.*, president, Blue Cross Association, New York City.

Housekeeping Plays Major Role In Control of Hospital Infection

Two Great Problems: Laundering Blankets Disinfecting Pillows, Mattresses

Because staphylococci survive in the dried state for many months, housekeeping plays a very important part in the control of infection. Housekeeping has to be designed to minimize the spread of infection.

Two great problems in housekeeping which remain unsolved are the laundering of blankets and the disinfection of pillows and mattresses. Since wool blankets sometimes shrink at high temperatures, laundrymen usually do not recommend that blankets be laundered at the same temperature as sheets. Therefore the temperature used is far lower than that which would be required to sterilize blankets.

Unjustifiable confidence is often placed in the addition of disinfectants to the water. The value of this method depends on the disinfectant and the method in which it is used. Also, the usefulness of the disinfectant depends on other elements used in the wash water. Certain detergents will interfere with the action of the quaternary ammonium compounds. Furthermore, bacteriological evaluation of rinse-water technics is very tricky.

Some researchers have found that the bacterial count on blankets can be reduced about 90 percent when CTA compound is used in the water. One Canadian group, in addition to using CTA, adds mineral oil to the rinse water to reduce lint. After a two-year trial of the method, this group concluded that although it is quite effective in killing staphylococci, it does not kill pseudomonas or tubercle bacilli, and therefore better methods must be found. There is quite a bit of enthusiasm about blankets of a synthetic fabric which may eventually replace wool blankets.—*Valerie Hurst, Ph.D.*, University of California Medical Center, San Francisco.

Warns of Hidden Costs in Operating Convalescent Unit

Average Occupancy Found Lower

If the need for more hospital beds is acute and if you find that your hospital has a growing number of patients who might be cared for in a convalescent unit, you might wish to consider establishing such a unit.

Some figures would lead you to believe that costs of operating a convalescent unit are much less than those for an acute-care unit. This is not necessarily so. There are hidden costs of operation of a convalescent unit. For example, our average occupancy in this unit is about 73.5 percent, as against more than 90 percent in medical and surgical units. Also, convalescent patients — predominantly postsurgical — receive as many medications as those on acute wards.—*Gordon W. Gilbert*, administrator, Huntington Memorial Hospital, Pasadena, Calif.

Specialized-Care Units Cost More; Some Costs May Be Reduced

Lists Factors to Consider In Setting Up Units

Every specialized-care unit is going to cost more money. The hospital may be able to reduce some costs through the greater utilization of equipment. Total cost to the patient may be reduced if he is eligible for some of the units which are less expensive.

Factors to consider in setting up these units are:

(1) Because some patients may still want special-duty nurses (if they can get them) and because there will be marginal patients who do not want to be in the intensive-care unit, you will get some duplication of equipment. Fewer breakdowns will occur, though, because people will know more about operating the equipment they are using.

(2) It will cost you more to man the intensive-care unit, because this type of nursing care requires special training. Personnel don't get this training in other hospitals. So you train them, and then they come to you and want premium wages.

(3) Turnover will probably be high. Extended periods of employment in these units has a depressing effect. Also, the work is very demanding.

(4) In hospitals that have a high occupancy rate over-all, this unit may tend to withhold beds from general use. Such units are not usually fully occupied.

Hospitals are legally obligated to give the patient the care he needs, whether or not he can afford to pay for special-duty care. Intensive nursing care, if you are a good cost accountant, should be charged to "room and care while hospitalized."—*Joseph L. Zem*, director, St. Luke's Hospital, San Francisco.

These Utah administrators are looking forward to next year's meeting, to be held in Salt Lake City, May 4-7. L. to r.: John H. Walker, executive secretary, Utah Hospital Association, Salt Lake City; Sidney G. Garrett, administrator, Logan Latter-Day Saints Hospital; Clifford McKinley, administrator, Sanpete Latter-Day Saints Hospital, Mount Pleasant; Clarence Wonnacott, administrator, Dr. W. H. Groves, Latter-Day Saints Hospital, Salt Lake City; and John H. Zenger, administrator, Utah Valley Latter-Day Saints Hospital, Provo. Mr. Zenger is the new first vice-president of AWH.

Expanded Role of Maintenance Chief Stressed by Panel Participants

Needs Knowledge of Sciences, Operation Of Complicated Equipment, Systems

The superintendent of maintenance and plant operations belongs with top management on policy-making. The hospital administration should check with him before a decision is made on new construction and on the purchase of new equipment.—*David E. Olsson*, administrator, San Jose (Calif.) Hospital.

Many refinements in modern hospital equipment came from suggestions of maintenance men. Increasing efficiency of maintenance and operations results from teamwork between the superintendent of maintenance and the administration. The maintenance superintendent can help architects and engineers to build good maintenance into new buildings.—*James Dowell*, chief engineer, Mount Zion Hospital, San Francisco.

Co-operation of the maintenance department has been very helpful to the nursing service. Only 20 years ago maintenance was done by the handy man, boilerman, and/or the nurses. Highly skilled maintenance personnel have relieved nurses of such duties, enabling them to spend more time on patient care. The maintenance department can help nurses to learn the proper uses of various pieces of mechanical equipment, and can advise them of any necessary precautions. Its personnel can provide training in fire prevention, and supervise a well-organized safety program, which aids hospital housekeeping. They can manufacture special items needed by the nursing service.—*Lois Dixon Jones, R.N.*, director of nursing, Peninsula Hospital, Burlingame, Calif.

Maintenance personnel in today's hospital must have a knowledge of chemistry, electronics, steam, and structure and architecture; of the operation of air-conditioning and refrigeration systems, pneumatic tubes, and elevators. The department's staff needs someone who understands operation and maintenance of large special equipment, such as heart-lung machines, and artificial kidneys.

The chief of maintenance or someone on his staff should have a working knowledge of blueprints to enable him to do trouble shooting through the many wires, tubes, and pipes that are in the walls of modern hospitals, and a knowledge of water chemistry for work with boilers, air-conditioners, and ultrasonic washers.—*Vittarina G. Lombardi, R.N.*, supervisor of surgery, Marin General Hospital, San Rafael, Calif.

Rehabilitation Program Results In 45% Increase in Discharges

Community Acceptance of Aged Called an Educational Problem

Through our hospital's rehabilitation program, there has been a 45 percent increase in the number of discharges to the community. Eighty-five percent of these discharges were to boarding homes or to the patient's own home. Only 11 percent of the discharged patients returned within the year. Of those, 90 percent had developed an acute illness and died after readmission.

Community acceptance of the aged as a part of society rather than apart from society is an educational problem. The maternalism and pity that many individuals exhibit for the aged reflect their own attitudes toward the later years. Separation of the aged from all other age groups in the economic and social life of the community likewise reflects a negative concept of uselessness and dependency.

The boarding home operators best suited to work with the aged are those who recognize their function as being managerial rather than motherly. An operator who tries to mother the patient can contribute to a discharge failure, as the patient will soon play the dependent role in the home and gradually reinforce his health limitations sufficiently so as to make him re-enter the hospital.—*Beverly C. Andre, R.N.*, associate director of nursing services, Orange County (Calif.) General Hospital.

Each day of the meeting, volunteers from a different San Francisco area hospital were very efficient and pleasant ushers and information clerks. This group, all from Peninsula Hospital, Burlingame, included (l. to r.): Mrs. Marie Miranda, Mrs. Bernice Manheim, Mrs. Nelson Davis, Mrs. Marion H. Kent, and Mrs. John C. Berg.

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A few of the ways in which a good accountant makes his services invaluable to a hospital are these:

— He keeps the administration informed concerning the state of the hospital's operating finance. For this purpose a monthly financial report consisting of a simple profit and loss statement and a balance sheet is not enough.

At our hospital, the administration receives daily information in the form of a daily business office report. This report serves as background for many decisions, such as timing of capital expenditures and determination of need for increased effort in the credit department. Obviously, only a skillfully operated accounting department could provide such information daily.

The trained accountant is also able to report to the administration, specialized information such as that contained in accounts receivable aging reports.

Another invaluable report, available from a good accounting department, is a monthly capital expenditure report with comparisons to the capital expenditure budget.

— In budget planning, a good accountant is vital since he is intimately concerned with its preparation. A careful budget is of utmost importance to the good financial management of any hospital.

— By setting up and maintaining good accounting and purchasing records, important in controlling supply inventories, the accountant can prevent the hospital from keeping thousands of dollars sitting idle unnecessarily in its storerooms.

— By supervising choice and installation of accounting machines, he can increase the effectiveness of accounting office personnel.—*John L. Brown*, director, Rockford (Ill.) Memorial Hospital.

Effective Orientation Program Benefits Both Management and Employee

Gives Worker Essential Information, Feeling of Belonging

An employee orientation program can serve a real need for the new employee, by familiarizing him with company history, rules and regulations, job duties and responsibilities, and the relationship of his job to others in the organization.

From the personnel department a new employee wants to know the nature of his work; how it fits into the work of the entire organization; who his boss is; to whom he can talk; where he will be working; the type of equipment or machines to be used; usual work week and hours of work; pay—rate, how computed, and when paid; opportunities for advancement; job stability and permanence; knowledge of the company—history and products or services; basis for promotion—seniority or merit; benefits—holidays, vacations, insurance, pensions, and credit union.

From the supervisor he wants to know departmental rules and regulations; what he is to do and why; who other members of the department are; to whom he is to report in the absence of his supervisor.

A program can be made more effective by having better supervisors and continuity of training; by planning the program carefully, allowing enough time to implement it properly; by being sincerely interested in new employees and showing it; by being patient; by encouraging new employees to ask questions and taking time to answer them intelligently; by being friendly, asking questions regarding the employee's work in a sympathetic manner—not as an attorney grills a murder suspect; by being sure that the program covers all necessary areas, and that the new employee understands channels of authority; and by following up and following through.—*Russell L. Moberly, Ph.D.*, director, Management Center, and professor of business administration, Marquette University, Milwaukee.

Department Teamwork Needed to Gain Patient's Co-operation on Diet

Patient Participation Important Factor

To be effective and accomplish its goals, the dietary service must be accepted by the patient. Since the dietitian cannot explain to every patient why he is being given certain foods, nursing and dietary services must work as a team to gain patient co-operation.

A good inservice training program can keep nurses informed on newer trends in dietary management, and can instruct auxiliary personnel also. These people can then help the doctor and the dietitian interpret dietary restrictions to the patient and also work with the dietitian in training the patient to follow a prescribed diet at home.

Patient participation is an important factor in achieving acceptance of a prescribed diet. The patient can help prepare his own dietary history. Proper questioning by the nurse or dietitian will reveal the

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HOUSEKEEPING MANUAL AVAILABLE

The complete housekeeping manual of North Shore Hospital, Manhasset, L. I., N. Y., has just been published by HOSPITAL TOPICS.

Selected illustrations and charts from the manual were used in connection with a series of three articles on the principles and practice of good housekeeping in hospitals, by Harry A Stroh and John Gondolfo, in the January, February, and March, 1958, issues of HOSPITAL TOPICS.

The manual is divided into seven main sections: I—Housekeeping Inventory of Physical Plant; II—Cleaning Standards; III—Organization; IV—Group Work and Job Descriptions; V—Workday Schedule; VI—Cycle Cleaning Schedules; VII—Check-out Schedules.

Copies of the manual may be purchased for $3 each from: HOSPITAL TOPICS, 30 W. Washington St., Chicago 2, Ill.

Over 2,400 Attend 29th Texas Hospital Meeting

A record-breaking attendance of close to 2,500 was registered at the 29th annual convention of the Texas Hospital Association in Dallas, May 5-8.

Mr. Earngey

W. P. Earngey, Jr., administrator, Harris Hospital, Fort Worth, was installed as president, succeeding Bolton Boone, D.D., administrator, Methodist Hospital, Dallas.

Winners of the first hospital public relations scrapbook contest, conducted by the association's council on public education, were presented with bronze plaques. Winning entries were submitted by:

Division I (1-50 beds)—Gladewater Municipal Hospital; Division II (51-150 beds)—Southwestern General Hospital, El Paso; Division III (151-300 beds)—Providence Hospital, Waco; Division IV (301 beds and over)—Baylor University Hospital, Dallas.

Purpose of the contest, which will be an annual event, is to stimulate interest in hospital public relations and to give recognition to hospitals having outstanding public-relations programs.

The oft-discussed problem of communications was the topic at one of the well-attended sectional meetings. The audience and speakers named these blocks to effective communication: ridicule; a general bulletin when an individual communication would suffice; an assumption by the person sending out the communication that the person to whom it goes knows what he is thinking; and failure to praise people often enough for their good work.

Resentment against change is not necessarily a symptom of lack of preparation of the employee, according to W. V. Mays, assistant administrator, Methodist Hospital, Dallas. He pointed out that sometimes an employee understands the explained reason for the change, but has done things the "old way" for so long that he does not wish to change.

The audience disagreed on the value of the "grapevine" as a means of communication. Everyone granted that it existed; some administrators felt that it could be used effectively to try out new ideas and proposed changes in existing systems. Others believed that trying out ideas on the grapevine is inadvisable, because there is no opportunity to give employees the accurate information on the proposals, and they might therefore misinterpret the ideas.

(Continued on next page)

Below, left: Tol Terrell, administrator, Shannon West Texas Memorial Hospital, San Angelo, and president, American Hospital Association, was honored by his fellow Texans at "Tol Terrell Night." Mr. and Mrs. Terrell are shown here in front of giant portrait of him. Mrs. Terrell holds a leather-bound volume of personal tributes, one of several gifts they received. Below, right: Texas officer Bolton Boone (l.), outgoing president, and administrator, Methodist Hospital, Dallas, is shown at one of sessions with F. S. Walters, Jr., administrator, Northwest Texas Hospital, Amarillo, who was named president-elect.

Among new THA officers are (l. to r.): Fred R. Higginbotham, administrator, Baptist Memorial Hospital, San Antonio, treasurer; Mrs. Luella H. Huffman, administrator, Upton County Hosptials, McCamey and Rankin, trustee; Albert H. Scheidt, administrator, Dallas County Hospital District, vice-president; F. S. Walters, Jr., administrator, Northwest Texas Hospital, Amarillo, president-elect; W. E. Arnold, administrator, Scott and White Memorial Hospital, Temple, trustee; Mother Mary Vincent, St. Joseph's Hospital, Fort Worth, trustee; and Carroll H. McCrary, administrator, Medical and Surgical Clinic-Hospital, Tyler, trustee.

TEXAS MEETING continued

Officers of the Texas Conference of Catholic Hospitals are (l. to r.): Sister Electa, Bethania Hospital, Wichita Falls, secretary-treasurer; Sister Marie, Seton Hospital, Austin, president-elect; Sister Mary Fidelma, St. Joseph's Hospital, Houston, president; Sister M. Altissima, Bethania Hospital, Wichita Falls, outgoing president; and Sister Aurelia, St. Elizabeth's Hospital, Houston, vice-president.

Panel participants in a sectional meeting on "Better Patient Care Through Better Nursing" were (l. to r.): Marjorie Bartholf, R.N., dean, School of Nursing, John Sealy Hospital, Galveston; Dorothy Haskins, R.N., director of nursing service, Parkland Memorial Hospital, Dallas; and Ruth Hamilton, R.N., director of nursing service, Harris Hospital, Fort Worth.

Boots were presented by the THA to guest speakers. Here Robin C. Buerki, M.D. (r.), executive director, Henry Ford Hospital, Detroit, removes boot of AHA executive director, Edwin L. Crosby, M.D., Chicago.

Government, Labor Spokesmen Discuss Health Care Problems

Address 1,200 Registrants at 28th Carolinas-Virginias Conference

William R. Huff, executive secretary of the West Virginia Hospital Association, was elected the first permanent executive secretary of the Carolinas-Virginias Hospital Conference, which met April 24 and 25 in Roanoke, Va. W. C. Bloxom, president-elect of the Virginia Hospital Association, and administrator, Johnston-Willis Hospital, Richmond, Va., will preside at the 1959 conference.

Approximately 1,200 people attended the Roanoke meeting, which included sessions on financing of hospital and medical care, the federal government's responsibility in hospital care, future trends influencing hospitals, problems of hospital management, and control of hospital infections.

UAW-Sponsored Group Is Experiment In Community Health Care

Group Practice Units Planned; Hope To Operate in Existing Institutions

Fundamental problems of financing hospital and medical care include the organization of personnel and facilities which furnish such care in a way so as to operate efficiently and productively; inclusion of a more complete range of needed medical services; establishment of proper controls to guard against unjustified inflation of costs; and concern of prepayment programs, on behalf of their members, over quality of care provided.

After evaluating community experiments throughout the country, designed to meet these problems, the United Automobile Workers sponsored the development of a community health plan in Detroit.

The Community Health Association was set up under the control of a board of directors representative of various interests in the community. Its membership comprises outstanding Catholic, Protestant, and Jewish religious leaders, a university vice-president, a judge, a banker, an electrical contractor, an industrialist, the head of a chain of department stores, and three labor officers.

In formulating basic policies for its program, the association received help from both the Kaiser Foundation Health Plan and the Health Insurance Plan of Greater New York.

Benefits under the program include home and office physicians' care, rehabilitation, and preventive health services.

Physicians in the program will be organized into group practice units in association with hospitals. It is hoped that these groups can operate in existing institutions, so that it will not be necessary, as in the Kaiser Plan in California, to duplicate hospital facilities.

With proper and competent professional advice, the prepayment agency will exercise control and set standards to assure high-quality medical care. The board's first official action was to call together leading physicians for a two-day discussion of how the quality of care under the program could be assured.

Features of the prospective CHA program include assurance that each individual in a covered group will get free choice between this program and a comparable open-panel plan. — *James Brindle,* director, social security department, United Automobile Workers, Detroit.

Hospitals Must Broaden Services to Meet Needs of Chronically Ill and Ambulatory

Graduated Care, Self-Help Units Two Possible Aids in Cutting Costs

Emphasis on expanded community hospital service is the philosophy of our times. Increased recognition is being given to these inseparable principles of a sound hospital program — care of the patient, teaching (including health education of the community), and research.

To meet the needs of the increasing number of patients who are ambulatory and those who are chronically ill or disabled, general hospitals must broaden their services and co-ordinate them to a greater degree.

Since the Hill-Burton program was amended to permit aid for construction of rehabilitation facilities and facilities for care of chronically ill and ambulatory patients, encouraging progress has been made. Nationwide, 67 rehabilitation facilities, 166 diagnostic and treatment centers, and 107 nursing homes have been approved for construction, and there are now 129 chronic-disease hospital projects.

(Continued on next page)

CAROLINAS-VIRGINIAS continued

The Public Health Service recently estimated that more than $10 billion for hospital and other health facilities will be required in the next 10 years to cover population increases, modernization needs, and replacement of obsolete structures. Half of this amount —$5 billion—will be needed to replace hospital patient-care units in operation 50 or more years. This dollar requirement represents a rate in excess of three times the expenditures during the first decade of the Hill-Burton program.

Since expenditures of this amount seems impossible, we must increase our efforts to keep people out of hospital beds, to make the most intelligent use of the plants we now have, and to take a determined and imaginative approach to the design and operation of new hospitals best suited to the patients to be served.

Graduate-care plans constitute one approach to solution of the costs problem. Two reports on this subject will be issued after the first of the year. One will be analysis of the organization and operation of the Manchester (Conn.) Memorial Hospital one year before the graduated-care plan was put into effect as compared with the hospital's operations one year afterward.

The second report will be a guide for hospitals on the elements of graduated care, explaining how to meet some of the problems that are encountered.

There are indications that self-service units for ambulatory patients can be operated at much less expense than regular hospital units.—*Aims C. McGuinness, M.D.*, special assistant to the secretary for health and medical affairs, U.S. Department of Health, Education, and Welfare, Washington, D.C.

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TRI-STATE

(Continued from page 28)

patient's attitude toward his diet, providing valuable information toward helping him adjust to it both in the hospital and at home. The patient should choose his own foods whenever possible.

If the patient understands the reasoning behind his diet, and its importance to him, and if he is allowed to participate in the decisions relating to it, he will co-operate with the dietary service in the hospital and follow the prescription diet when he leaves.—*Eleanora Sense, Ph.D.*, nutrition instructor, Chicago Wesley Memorial and Passavant Memorial Hospitals, Chicago; *Harley E. Cluxton, Jr., M.D.*, Passavant Memorial Hospital, Chicago; *Mrs. Byrtle Bump*, nursing service, Lutheran Hospital, Moline, Ill.; *Mary Norton*, dietary department, Evanston (Ill.) Hospital.

Management Plays Important Role In Work Simplification

Must Provide Belief In Program, Give Necessary Leadership

If a work simplification program is to be effective, it is essential that administration provide a climate favorable toward change. Management must provide leadership, belief in, and support of the program.

The goal of the program is to help the employee—to make his work easier. It is not a speed-up program, or a lay-off program, designed to increase the work load or reduce the number of workers.

It is an excursion into the art of human relations. Those participating in the program must do so of their own free will.

The program must be carried on with skill and efficiency so that it is accepted and respected.—*Donald J. Caseley, M.D.*, medical director, University of Illinois Research and Educational Hospitals, Chicago.

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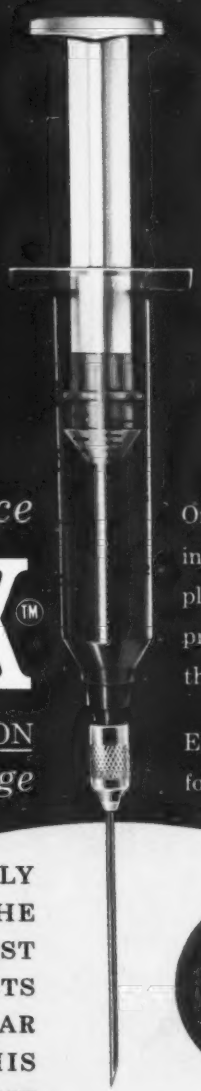

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Anesthesia Department Organization Discussed at New Orleans Meeting

Harold R. Griffith, M.D. (l.), Montreal, Que., Canada, presents honorary scroll of the society to Stanley M. Campbell, M.D., Toronto, Ont. Dr. Griffith is chairman of society's board of trustees.

TOPICS' report on the 32nd congress, International Anesthesia Research Society, March 24-27, New Orleans

More Private Hospitals Demanding Organized Anesthesia Service

Favors Billing Patient Separately at Home

More and more private hospitals are demanding the benefits of an organized anesthesia service, rather than a loosely-knit service in which anesthesia personnel respond only to needs pointed out by other medical staff members. Development of such a department involves many problems.

It is essential that a good relationship exist between the anesthesiologist and the administrator, since the administrator is the representative of the hospital's lay board.

The anesthesiologist needs to convince the administrator that patients will get better care if he serves as a consultant, as do other medical staff members. If patients are paying a certain sum each year for anesthesia services, and only a percentage of this amount is spent for these services, the patients are not getting full value for their money. Obviously the hospital must pay for equipment, but it should not make a profit on anesthesia service.

There should be a separate anesthesia department, and its members should participate in medical staff meetings. The medical staff must understand that the final decision as to the anesthetic to be used rests with the anesthesiologist.

Before joining a hospital staff, the anesthesiologist should spend some time visiting the hospital, talking to the staff. He should find out what staff members hope for from an anesthesia service.

We have developed our department on the basis of one anesthesiologist for 1,000 anesthesias per year. Staff members have formed a partnership. One of the responsibilities of any physician is to provide adequate coverage during his absence. A contract is needed. Terms of a "gentleman's agreement" are less likely to be confused if put into writing.

Since the anesthesiologist has little opportunity for direct contact with the patient, it is certainly advisable for him to meet the patient before surgery.

The method of billing may be an important way of establishing to the patient that the anesthesiologist is a physician. We prefer to bill the patient at home. I was warned that unless I collected from the patient before he left the hospital, he was a "lost cause"— but I have not found this to be true.—*Otto C. Phillips, M.D.*, director, anesthesiology department, The Hospital for the Women of Maryland, Baltimore.

(Continued on next page)

Physicians crowded into exhibit area to get latest information on new specialties available in their field.

ANESTHESIA RESEARCH continued

Epidural Anesthesia Gains Favor For Deliveries at Toronto Hospital

Used in 42.7% of Cases in 1957; Results Good in Mothers and Babies

The number of obstetrical patients receiving lumbar epidural blocks for delivery at the Toronto General Hospital increased from 34 out of 1,795 (1.9 percent) in 1955 to 731 out of 1,711 (42.7 percent) in 1957.

Condition of the babies has been good. The frequency of forceps delivery has not been considered a complication of the method. Of 103 vaginal deliveries, 17 were spontaneous.

After a block has been given, a rapidly progressing multiparous patient may be controlled much more satisfactorily than if she had received general anesthesia, because the periods of agonizing pain, writhing, and apprehension are abolished while preparations proceed for a controlled delivery.

Particular indications for epidural block are upper respiratory infections, toxemias of pregnancy, and prematurity. Of 81 patients having cesarean section in 1957, 50 had epidural blocks. Only contraindications, so far as the anesthetists are concerned, are severe hemorrhage, infection in the lumbar region, and central nervous system disease.

One possible complication is puncture of the dura. If this goes unrecognized and the anesthetic solution is injected, a high spinal anesthetic will result. In the one such case in our hospital, the patient became unconscious and stopped breathing 12 minutes after injection of the anesthetic. She was ventilated with oxygen, and her baby was delivered by low forceps. The patient gradually resumed full respiration and made a complete recovery.

We learned from this case that the anesthetist must remain with the patient for at least 20 minutes after injection of the anesthetic, and that oxygen for controlled ventilation resuscitation must be immediately at hand, as it is in most case rooms.

Blood pressure must be observed during epidural anesthesia, because occasionally there is a marked fall, and a vasopressor should be used. — *Shirley A. Fleming, M.D.*, senior anesthetist in department of anesthesia, Toronto (Ont.) General Hospital, and Stanley M. Campbell, M.D., Faculty of Medicine, University of Toronto.

Suggests Pentobarbital as Standard For Evaluating Sedatives for Children

No Agent Now in Use Reliable For More Than 75-80% of Cases

There is still no method which is both practical and reliable for sedation of children.

Most suggested programs use a preconceived dosage of sedatives based on body size. Since one child may be placid, and another extremely active, weight seems to be a poor method by which to estimate dosage. Other variables in a child's response to sedation make it

Doctors coming out of lecture session stopped to see scientific exhibit on new synthetic analgesic—Anileridine.

seem unlikely that it will be possible to select a single dose of any agent now in use that will be reliable for more than 75 to 80 percent of cases.

It would be desirable to devise a mechanism whereby the child would determine his own dosage. For example, a chloral hydrate lollypop, which the child sucks until he is sleepy, might be a simple way to provide self-dosage, if overdosage could be prevented.

We feel that it would be helpful if a standard could be set up to which other new agents could be compared. Because pentobarbital is well known, and fairly well understood, and continues to be one of the most useful sedatives available, it appears to be the logical one to use as a standard in relation to speed of action, sedative-depression ratio, cost, side-effects, and other parameters of action.—*Robert M. Smith, M.D.*, director of anesthesia, and *Mervyn Jeffries, M.D.*, associate in anesthesia, Children's Hospital, Boston.

mediately prior to electrical stimulation. The youngest patient was 13 years of age; the oldest, 87. Patients were not selected. Members of the anesthesiology department treated any patient that the psychiatrists felt required treatment.

There has been one death in the series. The patient vomited after injection of the succinylcholine in preparation for a second treatment. After resuscitation with oxygen, he left the floor in apparently good condition. He later developed pulmonary edema which failed to respond to treatment.

A second complication, the only other one in the series, was a mild aspiration pneumonia.

Thiopental sodium dosage has varied from 100 mg. to 250 mg. Dosages less than 100 mg. or in excess of 250 mg. have rarely been found necessary. A 2.5 percent solution is used. Dosage of succinylcholine varied from 20 mg. to 100 mg., with less than 20 mg.

Doctors examined controller-assistor at J. H. Emerson Co. booth (left), Xylocaine products at Astra exhibit, and Soda Lime at Mallinckrodt. Exhibits at right were those of Winthrop Laboratories (featuring Isuprel and Levophed) and Burroughs Wellcome.

Thiopental-Anectine Anesthesia Safe, Effective with Electroshock Therapy

Reduces Time, Effort Needed To Get Patients to Co-operate

Combined thiopental-anectine anesthesia seems to be the most effective, the safest, and the least anxiety-provoking method of administering electroshock therapy, in the opinion of the psychiatric staff at Hartford Hospital.

Psychiatrists have found that this method reduces the time and effort previously necessary to persuade a substantial number of patients to co-operate with their treatment. Although some degree of anxiety is common to all patients prior to their first treatment, it is minimized thereafter.

Between January 1, 1953, and December 31, 1957, 14,870 treatments were administered to 1,740 patients who received thiobarbiturate anesthesia and succinylcholine dichloride to produce muscular relaxation im-

being used on a very few occasions. We have found it impossible to relate the dosage to the weight of the patient, although the initial dosage is calculated roughly on the basis of the patient's height, weight, and age.

A brief period of apnea occurs in every patient undergoing treatment, but there has been no instance of prolonged apnea.—*Ranold J. M. Steven, M.D.*, and *Ralph M. Tovell, M.D.*, department of anesthesiology, Hartford (Conn.) Hospital.

Good Results Obtained with Pacatal As Supplement to Anesthesia

Physicians Praise Quieting Effect

Pacatal®, N-methylpiperidyle - (3) - methylphenothiazine, has been administered as supplementation to nitrous oxide - oxygen - thiobarbiturate anesthesia to 100 patients for various procedures. Good results were

(Continued on next page)

Bennett Anesthesia Assister was featured in Puritan Compressed Gas Corp. exhibit

ANESTHESIA RESEARCH continued

obtained in 60 percent of the cases; fair results, in 21 percent, and poor results, in 19 percent.

In our institution, we could not possibly select a few operations to be performed under identical conditions (same surgeon, same anesthesiologist), with and without Pacatal. Fortunately, however, we had a type of control which, we feel, presents enough evidence that the drug had a definitely potentiating effect.

Seven patients had previously had a similar or even identical procedure performed under nitrous oxide-oxygen-thiobarbiturate anesthesia, with or without meperidine supplementation, but without Pacatal. The amounts of thiobarbiturates used in these "control procedures" greatly exceeded the amounts necessary when Pacatal was used.

From the beginning of the study, we were impressed by the quieting effect of the drug. We gave 50 to 100 mg. to 10 subjects. In each instance an endotracheal intubation had to be performed while the patient was awake. The experience was tolerated by all of the patients with the utmost co-operation and without unpleasant memories.—*E. M. Kavan, M.D., V. L. Brechner, M.D., J. B. Dillon, M.D.,* and *L. A. Parker, M.D.,* department of surgery, division of anesthesiology, University of California Medical Center, Los Angeles.

Combination of Succinylcholine, Lidocaine Prolongs Apnea

Should Be Used with Caution

The respiratory depressant effect of repeated injection of succinylcholine and lidocaine was established in a series of experiments on dogs.

Lidocaine prolongs the apnea produced by succinylcholine in a statistically significant manner, and enables subapneic doses of succinylcholine to produce apnea.

The potentiation may be due to a competition of the two drugs for plasma cholinesterase.

In view of these findings it would seem that the combination of these two drugs in clinical anesthesiology should be undertaken with caution.—*Thomas J. DeKornfeld, M.D.,* Baltimore (Md.) City Hospitals, and *John E. Steinhaus, M.D.,* department of anesthesiology, University of Wisconsin Medical School, Madison.

The Foregger Co. showed the new Eifel model anesthesia apparatus, as well as other items in its line of anesthesia equipment.

Labeling, Research Spotlighted By Hospital Pharmacists

TOPICS reports on American Society of Hospital Pharmacists' annual meeting, held during American Pharmaceutical Association convention in Los Angeles

Plastic Substances Should Be Tested For Compatibility with Drugs

195 Solutions Tested on Three Plastics; Showed No Physical Incompatibility

Plastic substances, recently introduced to replace glass or rubber in such articles as containers, syringes, and tubings, should be tested for compatibility with various drug products.

Very little is known of the effect a plastic may have on a drug solution, or what effect the drug may have on the plastic, and at present there is no satisfactory method for predicting which plastic material should be used for a given drug.

In the past, incompatibilities have occurred, resulting, in some instances, in a change in the solution, in others, in an alteration in the plastic.

Leaching of one or several ingredients in plastic has been observed with various solutions over a period of time. Studies have shown that a plastic substance, even though sterile and pyrogen-free, can release an ingredient which causes toxic effects and irritation in animals.

In a compatibility study on three specially formulated plastic syringes, a total of 195 parenteral products were tested. Of these, 120 were official (U.S.P. or N.F.), and 75 nonofficial.

No incompatibility was noted in physical appearance, pH, or development of haze, after storage of the solutions in the plastic syringes for five hours, except in the case of poliomyelitis vaccine. The vaccine, in all three types of plastic syringe, faded from its original pink to an orange-pink.

Preliminary toxicity and irritation studies to determine whether harmful effects may be produced by the materials in the three plastic syringes have been negative. However, no chemical analysis was performed to ascertain if a reduction of potency occurred.

Results of one study, however, are not necessarily applicable to other plastic products even if the plastic material bears the same generic name. In addition, when studies are made, length of time and surface contact of the solution exposed to the plastic should parallel or exceed actual conditions of use.—*C. N. Dhorda,* graduate student, and *J. Autian,* assistant professor of pharmacy, University of Michigan College of Pharmacy, Ann Arbor.

Paul F. Parker (r.), director, division of hospital pharmacy, American Pharmaceutical Association, discusses meeting with Allen V. R. Beck, pharmacist, Indiana University Medical Center, Indianapolis, and M. A. Chambers (l.), professional service manager, William S. Merrell Co., Cincinnati, O.

Pausing during sessions are W. B. Shangraw (l.), senior member, Vermont State Board of Pharmacy, Rutland, and George F. Archambault, chief, pharmacy branch, division of hospitals, U.S. PHS.

Label Printing Machine Provides New Concept for Hospital Pharmacy

Achieves Savings in Time, Cost Releases Valuable Storage Space

The label printing machine provides a new concept in labeling for both large and small hospitals.

The average hospital pharmacy purchases printed labels for all standard stock items. An increasing number of hospitals prepackage standard stock using a new label with a control number on each newly-filled package.

(Continued on next page)

J. Autian (l.), assistant professor of pharmacy, University of Michigan, Ann Arbor, talks with J. L. Smith, Merck Sharp & Dohme district sales manager, Los Angeles.

HOSPITAL PHARMACISTS continued

While this method is most desirable for all hospital pharmacies, it requires a fairly large inventory of labels. These labels usually occupy space more valuable than their cost, particularly since they are usually purchased in multiples of 2,000 to 3,000.

After investigating the various label machines available and conducting time studies on their operation, we have found several advantages.

There is a definite economy of time and motion and of label cost. An unskilled operator can use the machine, and can set it up, print, and code 300 labels in about three minutes. These labels can then be applied to 300 containers in about five minutes.

Other advantages include the following points:

1. Since labels are printed as needed, a large inventory is not required. Thus valuable storage areas are released. Storage space will be needed for one or two sizes of blank labels in rolls.

2. Time is saved in control-coding the labels, since the number is printed at the same time as the label.

3. The control-code number always appears neat and even; when a rubber stamp or other device is used, the number may not parallel the main label printing.

4. When pressure-sensitive labels are used, a special hand-operated or electric dispenser can be attached which greatly facilitates application of the label to the container. The electric dispenser can be operated at a rate which will pace the work of the person applying the label.

5. Economy in actual purchase cost of labels results. Gummed labels in rolls, with name of hospital and a border printed on them, cost about 85c per thousand, as against $2 to $3 per thousand for commercially printed gummed labels. Pressure-sensitive labels cost about $2 per thousand for a large blank label and about $1.30 per thousand for a small label. These, in addition, are easy to print and apply.

6. Time is saved in counting labels since an exact number of labels, with control code, may be printed automatically by merely setting the predetermined counter.

7. Labels may be printed for use in other hospital departments. By use of individual metal type, any descriptive label can be printed, limited only by the size of the chase.—*Herbert L. Flack*, director, pharmacy service, and *Fred G. Salfi, pharmacy resident*, Jefferson Medical College Hospital, Philadelphia.

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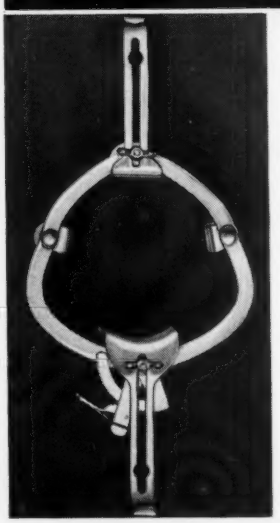

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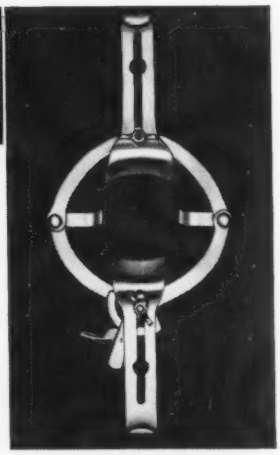

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MANUFACTURERS AND WHOLESALERS

Common Disinfectants Found Effective Against Varied Staphylococcal Strains

Antibiotic-Sensitive, Resistant Types Tested

In recent tests, several antibiotic-resistant and antibiotic-sensitive strains of staphylococci were equally sensitive to the action of commonly used hospital disinfectants.

Several classes of disinfectants, including phenolic, quaternary ammonium, and quaternary ammonium-iodine compounds, were evaluated *in vitro* over a six-month period, for their germicidal activity against antibiotic-resistant and antibiotic-sensitive strains of *Micrococcus pyogenes* var. *aureus*. These strains showed no correlation between their resistance or sensitivity to antibiotics and their resistance or sensitivity to the disinfectants used in the study.

Thus, it is concluded that the manufacturers' recommendations of dilutions for effective disinfection by their respective products may be relied upon for the destruction of both types of staphylococci.—*Carl L. Lawrence, Ph.D.*, director, Bureau of Laboratories, Los Angeles County Health Department.

Hospital Pharmacist Can Increase Value of Services by Teaching

Choosing Right Text, Organization Of Course Material Helpful

Hospital pharmacists often decline to teach pharmacology in the schools of nursing attached to their hospitals, not because they think they lack knowledge of the subject matter but because they feel inadequate as teachers. Learning a few of the basic steps of teaching will enable them to help meet the shortage of competent teachers of pharmacology, and at the same time increase the value of their services to the hospital.

The new teacher is wise to follow the textbook previously used for the course, referring to other available texts as he prepares succeeding lectures. Later, he will be able to choose the clearest text.

Once a text is chosen, the instructor should follow it; students often complain that instructors give them one text but teach from another. Since no course provides time to cover the entire text, it is often helpful to discuss, with other course instructors, sections in which subject matter overlaps, to avoid duplication.

In course content, the keynotes are simplicity and clarity. A general pattern of information may be followed for studying each drug. Included should be generic name, proprietary names, classification, action, uses, dose, side-effects and/or toxicity, and antidotes.

Quizzes and examinations should be used as teaching aids; they should be reviewed with the class, reteaching the most frequently missed questions.

Making up file folders for each course unit, in which may be gathered literature, ideas, and examination questions as they come to mind, will help to organize the teaching.—*Sister M. Gonzales*, chief pharmacist, and *Gerard Wolf*, assistant chief pharmacist, Mercy Hospital, Pittsburgh, Pa.

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Medical Specialist-Hospital Relationships

HOSPITAL TOPICS received so many mail and telephone inquiries regarding a recent item in the "Consultant's Corner" column about compensation of medical specialists that we asked Columnist Steinle to write an article on relationships between hospitals and medical specialists. The following article summarizes a series of special studies.—THE EDITORS.

By John G. Steinle

• For purposes of this article, medical specialists include radiologists, pathologists, anesthesiologists, and specialists in physical medicine.

In discussing the subject of medical specialists, the following areas should be emphasized:

— Organization of departments concerned with medical specialists

— Legal considerations in the hospital-medical specialist relationship

— Medical specialists and hospital authority and responsibility

— Types of contracts and agreements with specialists

— Compensation of specialists.

ORGANIZATION OF DEPARTMENTS

The organization of the departments concerned with medical specialists should not be confused with the types of contracts or agreements with specialists. The type of organization is primarily concerned with the functional responsibility of the radiologist, pathologist, anesthesiologist, and specialist in physical medicine for the operations of their entire departments. The contractual agreement determines the method by which the specialist is reimbursed.

The radiology, clinical laboratory, anesthesiology, or physical medicine department may be organized in three different ways.

1. The radiologist, pathologist (in charge of the laboratory), anesthesiologist, or specialist in physical medicine may operate the department for the hospital under a franchise or lease. He makes a fixed payment to the hospital for the equipment, space, and other items, pays all personnel whom he employs, and generally does his own billing. He is totally responsible for the internal administration of his department.

2. The radiologist, the pathologist, or the anesthesiologist may be administratively responsible to an assistant administrator or to the administrator for the operation of the department. In this situation, they serve as department heads and are completely responsible for all elements of administration of the department, under the direction of the administrator.

3. The radiologist, the anesthesiologist, and the pathologist may be responsible only for the professional activities of the department. A director, generally a lay person or a Sister, then is responsible for the administrative duties of the department. In this situation, all technicians report to the lay or Sister administrator, but are responsible to the physician in charge for technical aspects of operation of the department.

Physical medicine usually operates only on a franchise basis or as a department directly responsible to the administrator or to the assistant administrator. In the physical medicine department, generally it is not possible to separate the professional and nonprofessional functions.

Operation of the pathology, radiology, and anesthesiology departments has been complicated by questions regarding compensation of the specialists. There are some indications that this problem also will extend to physical medicine.

LEGAL CONSIDERATIONS

From early common law, it has been recognized as a legal principle that it is contrary to public policy to permit a physician to limit his liability. Consequently, it is not possible for physicians to incorporate in most jurisdictions. Conversely, it is not lawful for a hospital to "practice medicine."

The employment of physicians for performance of the x-ray, laboratory, and anesthesia functions has been challenged on a number of occasions by professional bodies and, on a few occasions, in the courts of law. The problem generally revolves around two questions: Does the performance of these functions, in effect, constitute the practice of medicine? Or, are they the usual functions provided to the physician to assist him in the diagnosis and treatment of his patients' ailments?

If the latter is the case, it may be said that such functions do not constitute the actual practice of medicine within the intent of the law.

When this question has been raised, the hospital's defense usually has been that the provision of x-ray, laboratory, and other services is similar to the provision of bed space or drugs to the patient. The hospital contends that such services, in themselves, do not constitute the practice of medicine; medi-

cine actually is practiced by the physician who utilizes the tests and reports provided.

The restriction against limiting the liability of physicians was more important in the past, when hospitals were not generally held liable for the acts of agents or employees of the hospital. In a number of early cases involving the liability of hospitals, the hospitals defended themselves on the grounds that the pathologist, radiologist, and anesthesiologist were, in effect, "independent contractors." In recent years, however, the trend in the courts has been to hold hospitals liable not only for the inherent activities of the hospital, but also for many activities which the courts have hitherto regarded as functions not appropriate to the hospital.

There have been several cases in which the hospital has been sued for the acts of the radiologist, the anesthesiologist, and the pathologist. However, these cases rarely come to a higher court on appeal. As a consequence, the question of the hospital's liability for the acts of these individuals still is unanswered. It may be stated generally, however, that the trend is in the direction of extending the liability of the hospital.

HOSPITAL AUTHORITY AND RESPONSIBILITY

Many practical considerations indicate the inadvisability of reducing the hospital's authority and responsibility for the pathologist, radiologist, and anesthesiologist. These may be summarized as follows:

1. The hospital needs the loyalty of all staff men and employees who work in close conjunction with its operations. Many hospitals have found that medical staff committees function more effectively when the membership includes radiologists and pathologists who have a critical attitude toward the operations and functions of the committees. This is particularly true with regard to the tissue committee and morbidity reports. It is generally conceded that it is more difficult for a radiologist and pathologist to maintain a critical attitude when they are dependent on the staff practitioners for their income.

2. When radiology and pathology are operated independently from the hospital, often there are problems concerning free patient care. If the operation of these departments is contracted for, or leased to, a practitioner, he feels he is entitled to make a separate determination as to whether the patient should receive free care or be given reduced charges.

3. The operation of these departments independently from the hospital presents a number of problems of internal control and administration. Administrative functions of the hospital may be performed separately from the administrative functions of these departments. For example, billings and over-all administration and operation require separate actions. This separation often creates a conflict between employees of radiology and pathology, and those of the rest of the hospital. Usually it is very difficult in contract or franchised departments to have a fixed salary program which coincides with the salary and personnel policies of the rest of the hospital.

4. In many areas, Blue Cross, welfare departments and other agencies make flat per diem payments for all elements of care of the patient. Also, if a hospital has inclusive rates, it is very difficult to separate the charges for laboratory and x-ray from the charges for room, board, and other elements of patient care.

5. A hospital is dependent for its income, to a large degree, on these departments. It is generally argued that, even though these departments show a profit, it is essential that the rest of the hospital be available so that they may operate effectively and have a demand for their services.

TYPES OF CONTRACTS AND AGREEMENTS

There are probably as many types of agreements and contracts with medical specialists as there are hospitals. It is not at all uncommon to find one type of contract for one specialist and an entirely different kind of arrangement with another medical specialist in the same hospital. For example, in one hospital it was found that the x-ray department was on a lease basis, the anesthesiologist received all of the income from the department, and the pathologist received a percentage of the gross income from the laboratories.

While there are many different kinds of agreements and combinations of agreements, a study of 100 hospitals indicated that the principle methods are:

Direct employment by the hospital. The medical specialist receives a fixed salary from the hospital.

Percentage of gross. The medical specialist receives a percentage of the gross income for the department. His contract generally specifies what constitutes " gross income." The major problem in this type of agreement involves free patient care. Some hospitals include all billings in the definition of "gross." Others compute the "gross" on the basis of all normal charges and deduct a fixed percentage of these charges for free patient care and for reserve for uncollected debts.

Percentage of net. Again there is a difficult problem in determining what constitutes net profit. The majority of hospitals compute the net by including all income from the department concerned and deducting salaries and overhead. The definition of overhead usually presents a problem. Some hospitals depend on a complex cost-accounting system to determine overhead; others simply deduct a set amount.

Rental of equipment or other payment to the hospital by the medical specialist. In this arrangement, the medical specialist receives all income from the department and pays the hospital for the space and occasionally for rental of equipment. The payment to the hospital may be on an agreed lump-sum basis, a percentage of gross, or a percentage of net.

(Continued on next page)

Hospitals involved in this method usually encounter substantial friction over the provision of free patient care. It is not at all uncommon in such a situation to find the hospital providing care free or at a charge below the standard rate, while the medical specialist presses the patient for payment of full charges. It is reported that these arrangements often cause strong resentment among other medical staff members, particularly those who spend considerable time providing care to service patients.

While these are the most common bases for contractual relationships between hospitals and medical specialists, it is not at all unusual to have a combination of these methods of compensation in a single agreement. For example, one hospital has an agreement with the radiologist by which he receives a salary, plus a percentage of net from inpatient work. He collects for private ambulatory patients and pays the hospital a percentage of the gross for this work.

It is obviously very difficult to identify the principle agreement factors between hospitals and medical specialists. However, the following constitutes an attempt to classify agreement factors in 100 hospitals of various sizes in the eastern states. The totals for radiologists, pathologists, and anesthesiologists exceed the 100, because in some instances the combination of compensation methods included more than one system. There were only 21 hospitals with physical medicine specialists.

Methods of Compensation

	Radiologist	Pathologist
Salary	23	32
% of Gross	42	30
%of net	39	39
Payment of Hospital	7	4
	Anesthesiologist	**Medicine**
Salary	12	14
%of Gross	29	3
% of Net	15	2
Payment of Hospital	53	2

———COMPENSATION OF MEDICAL SPECIALISTS

Interviews with medical specialists and hospitals indicate that the principal factor determining hospital-medical specialist relationships is not the method of agreement but the actual amount of money that the medical specialist receives.

The problem of compensation of the medical specialist is not a unilateral one created by the selfishness of the individual. Today, the real earning period of the average medical specialist does not begin until he is 34 years of age. His average number of productive income years is only 24.7 (based on a study of actuarial income and life-expectancy statistics)—substantially below that of other professional groups. Consequently, the average medical specialist has a tremendous compulsion for high income.

An attempt was made to determine the payments to medical specialists by 35 hospitals ranging in size from 200 to 350 beds. Only hospitals that had full-time medical specialists were included in this study. The income shown is that of the chief of the department. The fact that medical specialists in smaller hospitals may derive their income from more than one hospital makes it difficult to identify their total income. In larger hospitals unusual conditions often prevail.

Compensation was computed without regard to form of agreement. Following are the results:

Radiologists:

4	—	$18,000 - 22,000
6	—	22,000 - 26,000
10	—	26,000 - 30,000
7	—	30,000 - 35,000
5	—	35,000 - 40,000
3	—	over $40,000

Pathologists:

7	—	$18,000 - 22,000
7	—	22,000 - 26,000
9	—	26,000 - 30,000
7	—	30,000 - 35,000
3	—	35,000 - 40,000
2	—	over $40,000

Anesthesiologists:

5	—	$18,000 - 22,000
6	—	22,000 - 26,000
8	—	26,000 - 30,000
6	—	30,000 - 35,000
6	—	35,000 - 40,000
4	—	over $40,000

The average incomes were as follows:

—Radiologist	$32,300
—Pathologist	$29,600
—Anesthesiologist	$33,400

If we assume that it is desirable to have the medical specialist administratively responsible to the hospital and that the major problem is one of amount of money rather than the form in which it is paid to the specialist, then the hospital must develop a satisfactory method for payment, preferably with attractions not available in situations in which the medical specialist is entirely an independent contractor.

A particular opportunity presents itself through the deferred-income system, with which the hospital can expand the period of income for the physician beyond his ordinary earning years at a tremendous tax savings. For example, a medical specialist with an annual income of $35,000 per year for 20 productive years will receive a total of $700,000 over the 20 years. He will pay, at the present rate, with normal deductions, $170,400 in taxes, thus receiving a net income of $529,600, or an annual average of $26,-

(Continued on page 47)

Above: Large photograph shows compactness of filmstrip package. Inset: View from exhibit on "The Hands in Arthritis and Related Conditions" (Filmstrip 2, Part I).

'Exhibits-on-Film': New Teaching Aid

WHEN the American Medical Association meets in San Francisco this month, a crew of medical journalists and photographers will cover the many aisles of scientific exhibits to obtain material for a filmstrip report on the year's outstanding work. Later the films will be made available for teaching purposes through a unique service—"Exhibits-on-Film."

The service is designed to preserve significant "graphic reporting" in medicine—scientific exhibits from major annual medical conventions—so that individual physicians as well as faculty members and students who did not have a chance to visit the exhibits in person will be able to study them in detail.

Exhibits-on-Film is supported by Lakeside Laboratories, Inc., which has established the master library and made a similar library available on re-

(Continued on next page)

quest, at no charge, to all medical societies, teaching hospitals, and medical colleges.

Each addition to the library consists of small cans of filmstrips, a long-play record, and printed instructions. The material is easily filed in medical school or society libraries.

Besides showing the exhibits themselves, the filmstrips (in full color, with sound) provide much supplemental information. The exhibiting physicians answer many of the questions asked by visitors to the exhibits at the conventions.

Already available are three filmstrips showing six scientific exhibits from the 1957 AMA convention, including the two which received the top awards—the Billings and the Hektoen gold medals. They include:

Filmstrip 1, Part I: "The Present Indications for Cardiac Surgery," by Glover, Davila, and Trout, Philadelphia (Billings gold medal winner); Part II: "Oral Organomercurial Diuretics," by Dimitroff and Griffith, Los Angeles.

Filmstrip 2, Part I: "The Hands in Arthritis and Related Conditions," by Crain, Washington, D. C.; Part II: "Intramuscular Iron for the Treatment of Iron Deficiency Anemia in Infancy," by Wallerstein and Hoag, San Francisco.

Filmstrip 3, Part I: "Bronchial Asthma," by Irwin, Itkin, Weille, and Little, Boston; Part II: "The Direct (Open) Surgical Repair of Congenital and Acquired Intracardiac Malformations," by Lillehei, Warden, DeWall, Gott, Sellers, Cohen, Read, Varco, and Wangensteen, Minneapolis (Hektoen gold medal winner).

Scheduled for early release are films covering exhibits from meetings of the American Academy of Pediatrics and the American College of Physicians.

Hospital personnel interested in seeing the filmstrips are asked to contact their superiors, who may check either with the nearest medical college library or with the county medical society. Individual physicians who wish to see them are asked to get in touch with the executive secretaries of their county medical societies.

Complete libraries will be made available on a continuous and permanent basis to any medical school and county, state, or regional medical society, from "Exhibits-on-Film," Lakeside Laboratories, Inc., 1707 E. North, Milwaukee 1, Wis.

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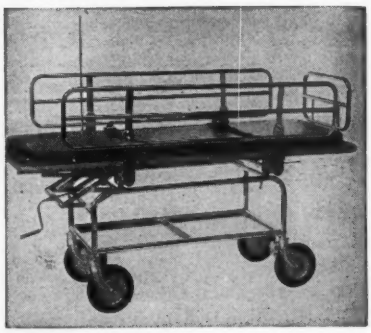

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The author, John G. Steinle (fourth from right), and the class of hospital administration at the American University of Beirut: (l. to r.) Dr. Somsong Kanchanahuta, department of medical service, ministry of public health, Bangkok, Thailand; Farangis Yadegarjam, Tehran, Iran; Nazar Mustafa Al Khalil, ministry of health, Baghdad, Iraq; La Vande Syverson, instructor in hospital administration and assistant administrator, American University Hospital; Mr. Steinler; Salman Saud Al-Ami, Royal College of Pharmacy and Chemistry, Baghdad, Iraq; Kutchek Kambakhsh, Tehran, Iran; and Dr. Abu M. A. Hayat, Rangpur, East Pakistan. At right: Richard E. Sawyer, administrator, American University Hospital, Beirut, Lebanon.

The World and Medical Care—Part II:

Arab Countries Strive to Improve Formerly Primitive Care

By John G. Steinle

EDITOR'S NOTE: This is the second in a series of reports by HOSPITAL TOPICS' consulting editor, John G. Steinle, on his recent tour of hospitals and medical education facilities in Europe and the Mid-East. Part I appeared in May.

For this particular installment, since the author felt that political issues so strongly influence all phases of life in Arab countries, we took it a little easier with our blue pencil and let Mr. Steinle voice some of his opinions on the key issues and their relationship to medical care and education.

This article does not include a discussion of Israel, which could not be visited from Arab countries.

• The entire political, cultural, and economic picture in the Near East is dominated, I found, by Nasser, the Israel question, and oil. Closely entwined in all three is Russia's determination to expand its influence in the Moslem world and the United States' determination to fill the void created by the decline of French and British influence.

Russia has seized every opportunity to picture Uncle Sam as a greedy Goliath gobbling up the weak and unprotected. The American visitor is plagued by questions about Little Rock, and allegations of United States feudalism in Central and South America and support of the French in an "attempt to reconquer Morocco."

The Arab cannot understand how American aid to educational and health projects can be used as a political weapon if the United States is altruistic. Nor can he understand the relationship of economic aid to Arab countries and an alleged "balance in aid" to Israel, since the population ratio is 40 to one. American authorities deny that health and educational projects are used as means of political pressure or that economic aid to Arab countries is controlled by the amount of funds allocated to Israel.

Russia seems to have succeeded not only in deprecating the means, amount, and motives of American aid, but also in exaggerating its own grants, which are actually loans.

Many Arab leaders believe that the normal direction of gravitation of the political and economic thought of their people is to the West, particularly toward the United States. They point out that the Arab is an independent nonconformist by nature and abhors regimentation. He has a strong belief in God and a rigid moral code, although it is different from the American code. Furthermore, the American colleges and universities in the Mid-East, particularly the American University of Beirut, have had a tremendous and positive influence on Arab leaders.

The average Arab leader is quite concerned regarding the allegation that the Arab countries are playing Russia against the United States to obtain more economic aid. As one leader stated: "This is not a matter of blackmail—simply a matter of getting food and clothing for our people. A hungry

(Continued on next page)

man is not concerned about the politics of his benefactor."

On an escorted tour through a Cairo hospital, the administrator, whom I had known for a number of years, turned to me and said, "Of course our equipment is not up to American standards, but it will improve as we receive more aid from Russia. Their immediate help had to be military so that we can first defend ourselves." This was stated as a fact and with no sign of rancor or bitterness.

The fact that Havre, Montana was listed as my birthplace on my passport seemed to remove some of the suspicion of pro-Zionist sentiments, which the Arabs ascribe to Americans, particularly those from New York.

The Israel question has been kept boiling by Russia and Nasser. The most liberal and intelligent Arabs are anti-Israel, if not anti-Jewish. It is impossible to extricate the truths from the untruths, the propaganda from the facts, the fictions from the accuracies.

There seems to be little question that both Jews and Arabs have been guilty of inequities. Thousands of Arab Palestinians left their homes when war first threatened between Israel and the Arab countries. The Israelites ask whether or not we would feel justified in seizure of property owned by persons who "deserted" to the enemy in time of imminent attack. The Arabs say that evacuation was made necessary by actual or threatened persecution and abuse.

Whatever the facts, it seems apparent now that Nasser and his adherents do not want the problem of the Palestinian refugees settled. Great pressure has been put on Iraq not to resettle refugees on land recently reclaimed from the desert by irrigation. Buildings of a refugee orphan boys' center, founded by a wealthy Palestinian, have been attacked and burned by other refugees. Sixty percent of the more than 100 persons arrested for terrorist activities in Lebanon were from refugee camps.

Lebanese political leaders are privately disillusioned at the reluctance of refugees to be assimilated. The normal population growth in many camps has been greater than the number of persons who have obtained jobs and left the camps.

The Arabs are very friendly people, although they are sometimes inclined to be suspicious of strangers. If a friend or relative is sick, it is simply good manners to visit him at least once if he is a casual acquaintance and every day if he is a neighbor in the same or adjacent building. If he is a cousin or a closer relative, at least a daily visit is considered mandatory.

At the American University Hospital, Beirut, Lebanon, the average number of visitors per patient is 2.4 times greater than that for comparable hospitals in the United States.

Medical Care and Education

Until recently, medical care in the Mid-East, except for a few isolated exceptions, has been at best primitive. Each country, in its own way and in varying degrees, is attempting to solve its problems.

Initially, a great deal of emphasis is being placed on preventive medicine. The United Nations Relief and Works Agency for Palestine refugees in the Near East (UNRWA) has inoculated all adult and child refugees against diphtheria, smallpox, and tuberculosis. (There are an estimated 900,000 refugees, of whom 300,000 are in U.N.-operated camps. Seventy percent of the money for the operation of these camps is provided by the United States.)

An effective malaria eradication program has been developed in Iraq by the World Health Organization. Iran, Saudi Arabia, and Syria are also developing programs. Extensive work is being done in Iraq on trachoma, one of the most common diseases in the Mid-East.

The WHO has established a school health program in Syria, and tuberculosis control programs in Egypt, Iran, Iraq, Israel, and Syria. This agency has given assistance in control of venereal disease in Pakistan and Saudi Arabia, and aided a mental health program in Jordan. In the past five years maternal and child health programs have been established in Iran, Libya, Jordan, Pakistan, and Syria.

Except in the modern hospitals established by the oil companies and in the American University of Beirut Hospital and other hospitals aided and influenced by foreign countries, medical care and facilities by our standards are primitive. Egypt is attempting to establish a universal health program under which care would be provided in government hospitals. The principal problems in this country are the shortages of trained physicians and other manpower and of equipment and facilities.

Iraq is making perhaps the best-planned attempt at meeting its health problems. It is establishing a science center designed to train all types of medical specialists. Diagnostic clinics and referral hospitals are being constructed throughout the country. A comprehensive medical care program is being inaugurated. Pakistan, Syria, and Lebanon have programs providing medical care to all persons, but only in Lebanon is there an adequate number of physicians, and they are concentrated in the cities. In Saudi Arabia and Jordan there is not a single native physician or nurse.

While the United States "Point Four" program has developed malaria eradication and other programs in these countries, its greatest contribution has been in training medical specialists, including nurses, physicians, health educators, sanitary engineers, and hospital and sanitarium administrators. One of the principal resources for training these individuals has been the American University of Beirut.

Medical education in the Near East has been

Above: Student nurse receiving instruction in pediatrics. At right: Student nurses entering American University of Beirut Hospital.

largely influenced by the former protectorate governments. Syria and Lebanon have "French" medical schools. Iran, Iraq, Egypt, and Pakistan follow the English program, with its heavy emphasis on preclinical subjects.

Egypt has been developing its own system, which is characterized by tremendous acceleration. The Cairo University Medical School, founded by private English funds, which for years has enjoyed an excellent reputation, has been connected to a government school with classes ranging in size from 850 to 1,000. Nearly all training is didactic. Clinical experience is almost nonexistent.

Iraq is attempting to solve its manpower shortages by training "medical technicians." The theory is that there is not time to train a few men well, to perform many tasks. Consequently, many men and women are being trained to perform very specific medical tasks.

Of particular interest to the American visitor is the American University of Beirut Medical School. It follows closely the American system of medical education. Minor adjustments have been made in the curriculum to meet local needs. For example, because of the tremendous amount of eye disease in the area, this has been made a major subject. The school's program is five years in duration. The fifth year, in effect, is a rotating internship at American University of Beirut Hospital.

The school was incorporated in the State of New York and comes under the surveillance of that state's board of regents. The faculty is composed of well-known authorities from other countries as well as from the United States.

The 220-bed American University of Beirut Hospital has contributed greatly to the prestige of the United States in the Mid-East. It has become the hospital to which complicated and difficult cases are referred from the entire area. The hospital is accredited by the Joint Commission; the medical school, by the Association of American Medical Schools. All programs and classes are in English.

MEDICAL SPECIALISTS

(Continued from page 42)

480 net per productive year. However, if after retirement he should live an additional 10 years, his average income for the 30 years would be $17,533.

If, instead of taking his full income during his productive years, he received $29,750 and the hospital purchased a $5,250 annuity, he would pay taxes currently on the $29,750 and on the $5,250 when the annuity was paid. He would receive over the 30-year period a gross income of $754,000 with the increased income from compounded interest on the annuity and would pay a total of only $134,200 in taxes.

Thus, his average net income after taxes over the 30-year period would be $20,660, or approximately $4,000 more than if he took his total income when earned. According to present tax laws, 15 percent of income can be used by the hospital to purchase annuities.

The deferred income is not available to the medical specialist unless he is paid by the hospital.

SUMMARY

There are many reasons why the medical specialist should be a part of the hospital staff rather than an independent contractor. There are many methods of compensating medical specialists. In most instances the contract method is developed to support an approximate reimbursement.

Deferred compensation provides an excellent opportunity to hospitals to assure the continued relationship with the medical specialist as a part of the hospital team, and assures the medical specialist of a larger net income at no additional cost to the hospital.

Regional Differences in U. S. Hospitals

By Louis Block, Dr. P.H.

*Daily Newborn Census**

Sixth in a series

● There are regional differences in the numbers and kinds of hospital facilities and services available, and in their utilization. The role of the regional hospital can best be portrayed by studying it as a part of the total United States picture, and as an entity in itself.

The largest daily newborn census in:

1. All hospitals are in the Middle Atlantic and East North Central regions.

2. Short-term general hospitals are in the Middle Atlantic and East North Central regions.

3. Nonprofit short-term general hospitals are in the Middle Atlantic and East North Central regions.

4. Proprietary short-term general hospitals are in the Middle Atlantic and West South Central regions.

5. Governmental (excluding federal) short-term general hospitals are in the South Atlantic region.

Practically all the newborn census is in short-term general hospitals. Most of these are in nonprofit, controlled hospitals in all regions.

1. The Region as a Part of the United States

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific	Total
Total	6.6	22.2	12.5	22.1	4.4	10.3	6.7	4.5	10.7	100.0
Short-Term General	6.8	22.6	12.0	22.6	4.4	10.4	6.3	4.3	10.6	100.0
Nonprofit Short-Term General	8.0	24.4	8.5	25.2	3.2	10.7	4.6	4.7	10.7	100.0
Proprietary Short-Term General	1.9	20.2	17.9	3.6	10.9	6.6	21.0	2.0	15.9	100.0
Gov'tal (Excl. Federal) Short-Term General	3.1	16.3	24.5	17.1	7.2	10.2	9.6	3.4	8.6	100.0

2. The Region as an Entity in Itself

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
Short-Term General	97.1	98.3	91.2	98.1	94.1	96.3	89.8	91.3	93.9
Nonprofit Short-Term General	87.6	81.0	49.8	83.5	53.7	75.8	50.1	76.0	72.9
Proprietary Short-Term General	1.3	4.2	6.5	0.7	11.2	2.9	14.3	2.0	6.8
Gov'tal (Excl. Federal) Short-Term General	8.3	13.1	34.9	13.9	29.2	17.6	25.4	13.3	14.2
Other	2.9	1.7	7.8	1.9	5.9	3.7	10.2	8.7	6.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Based on the 1956 Administrators' Guide Issue, *Hospitals*, Journal of the American Hospital Association.

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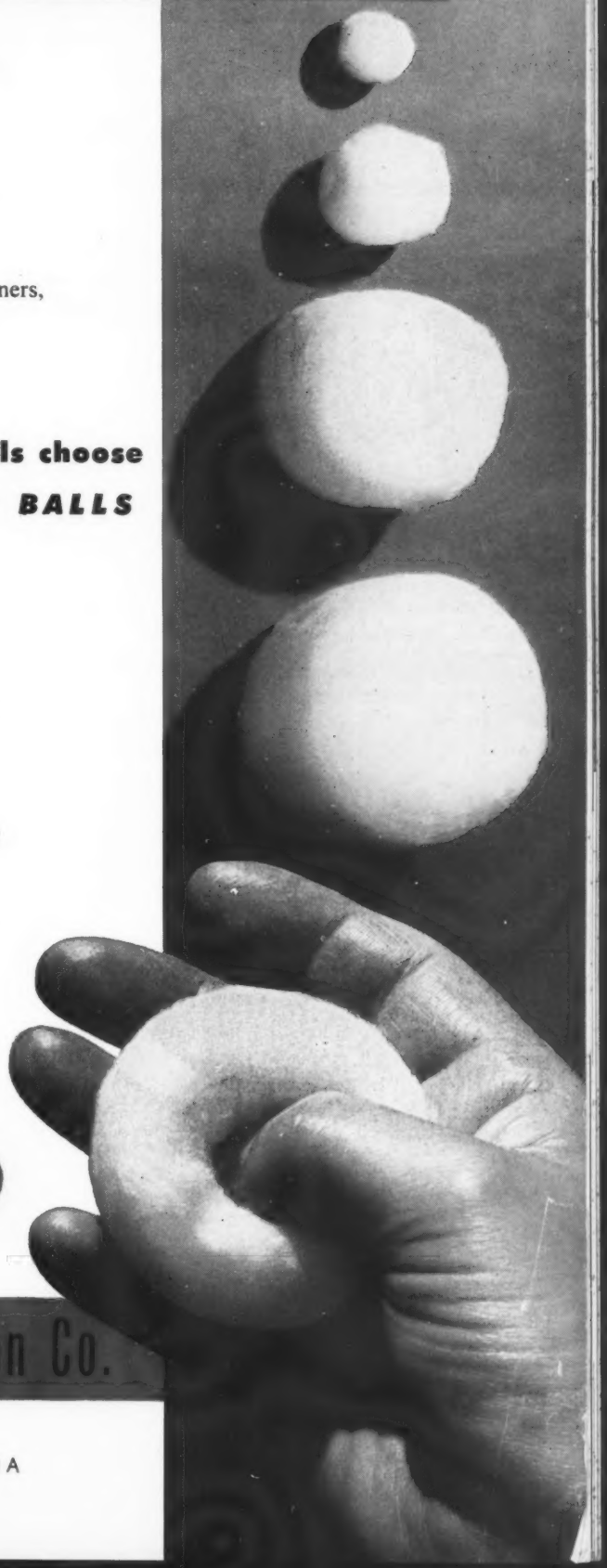

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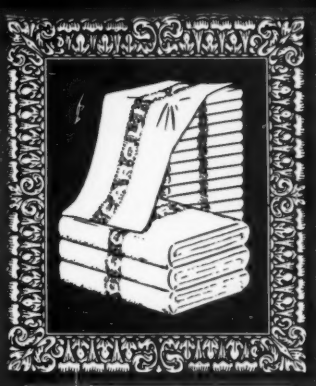

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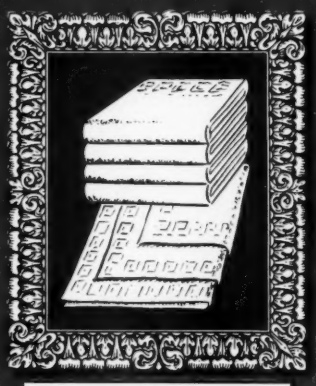

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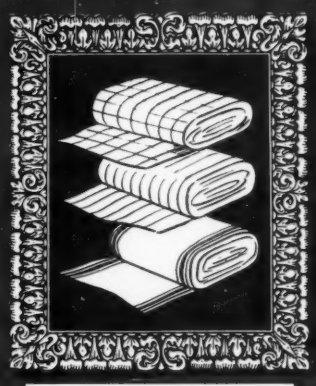
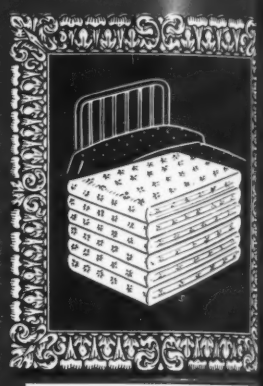


TOWELING



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The Carolina Gallery shown above pictures only a few of the items Carolina regularly supplies to hospitals Our textile line is complete, and tastefully selected with the patient also in mind. Our Surgical dressings are quality products, designed for service and economy. If you do not have a complete set of Carolina catalogs at your finger tips, write for a copy.

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Consultant's Corner

By John G. Steinle

Q. We are attempting to negotiate a loan and have been told that there will be a "finder's fee" of two percent. Please explain.

A. Finder's fees are fees charged by persons arranging loans. The amount of the fee and who pays it will depend on the loan market. If loans are hard to get, in what is known as a "tight market," the borrower will ordinarily pay the fee. If mortgagors are looking for loans to make, in a "soft market," then they will pay the fee. Specialists in loans advise that two percent, paid by the borrower, is reasonable in the present market.

Q. Is there anything wrong in a commercial organization's providing a diaper service to a hospital in exchange for a list of all maternity reservations?

A. Yes. Such an arrangement is exceedingly bad public relations. Every patient is entitled to her privacy. Routine publication of birth lists is usually done in accordance with legal requirements for registration and thus, is not an invasion of privacy. Giving the reservation list to a commercial firm in advance of the patient's admission is an invasion of the patient's right of privacy.

Q. Do you recommend flasking or a sterile water tank for sterile water preparation in central sterile supply?

A. Flasking is the only method recommended. It provides terminal sterilization. The container as well as the fluid is sterilized in the single process. Even when sterilization is achieved in the sterile tank the container must also be sterilized. In the tank itself there are always points of probable contamination.

Q. How long should x-ray plates be kept? Is there a specific statute of limitations that applies?

A. In most states there is no specific statute of limitations. Hospital attorneys agree generally that records should be kept as long as the statute of limitations permits the bringing of a damage suit or a malpractice suit. For malpractice and damage suit actions, the statute of limitations period is one year in most states but in some is as long as six years (for malpractice in South Carolina).

You should ask your attorney to advise you on the statute of limitations for bringing these actions in your state. It should be remembered, however, that the statute of limitations does not begin to run against a minor until the child comes of age.

The older the film, the less likely it is to be needed. Analysis indicates that x-rays are seldom required after six years. Except in the case of minors, six years will meet all requirements for the statute of limitations. Films of children, if they are other than routine, should be kept until the child achieves majority plus one year. In most states, that will be until the patient is 22 years old (21 years of age plus one year).

Medical factors should also be considered in adopting a policy for disposal of x-ray films. All films should be reviewed before disposal so that teaching and research material is not destroyed.

Q. What are the possibilities of selling used x-ray film? Ours is a 150-bed hospital located more than 200 miles from a major urban center.

A. All urban centers have dealers who purchase x-ray film for silver recovery. Recently a nationwide service was established which offers a choice of the following: (1) outright purchase of x-ray film at a fixed charge per pound, or (2) refining on a lot basis. The hospital receives full assay content value of recovered silver less a specified service charge. The recovered silver is paid for at the prevailing published market price of silver, now about 90 cents per troy ounce.

The average 150-bed hospital uses about one ton of film per year. In lots of one ton, the hospital would be better off accepting the recovery price. For smaller lots it should sell the film outright. For details about this plan, write Handy & Harman, 82 Fulton St., New York 38, N. Y.

Q. Is it usual for a hospital to handle its own adoption problems?

A. No! The hospital should never handle adoption problems. I am told that today there is no area of the country that does not have a social agency especially equipped with personnel experienced in the solution of such problems. Adoption proceedings are always involved and cumbersome and time-consuming for hospital administrators who could be spending their time more profitably on direct hospital business.

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1 attain the highest degree of cleanliness ever achieved,

2 . . . at a speed which saves money for the hospital.

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Since its introduction to hospitals by American Sterilizer, Ultrasonic cleaning has clearly proved itself the method of choice for the fast, and effective removal of soil from surgical instruments, syringes and related items, prior to sterilization.

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Shown at the left is the new portable Model UC-79. Its 7" x 9" bath incorporates the same proved Ultrasonic principles as the larger unit and attains the same amazing cleaning efficiency.

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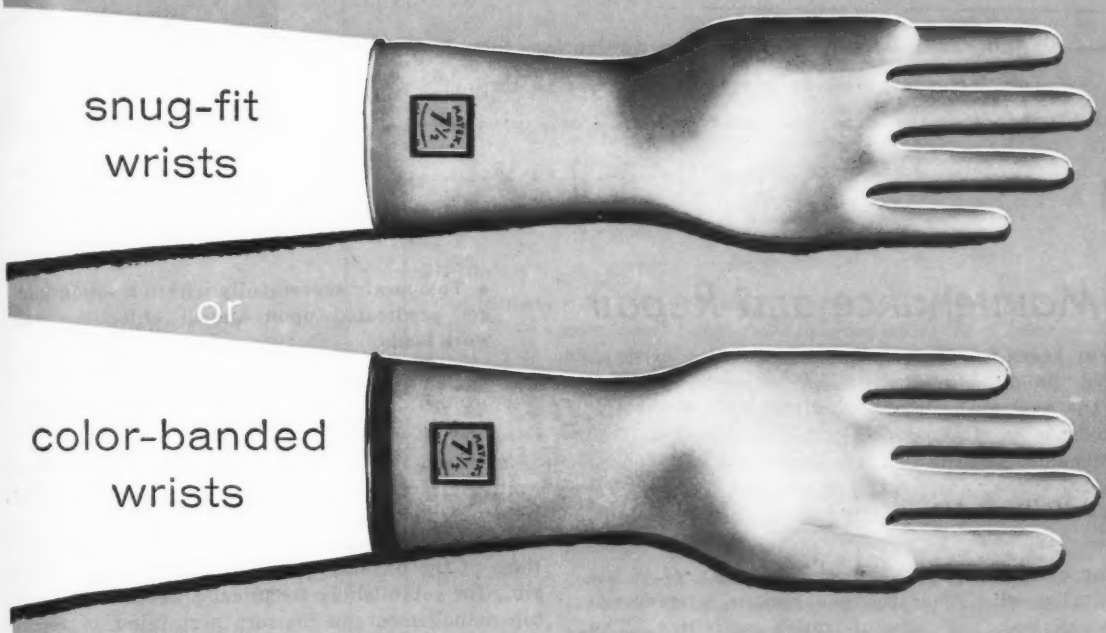

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Plant Operation and Maintenance

Another in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

I. Maintenance and Repair

• For years hospitals attempted to operate with so-called "handy men." But a handy man is not enough for the modern hospital. One-third the initial cost of today's hospital is for electrical and mechanical equipment. Records indicate that the cost of maintaining and operating this equipment far exceeds that of equipment in any other single part of the hospital.

Any breakdown in the mechanical features of the hospital results generally in a serious interference with clinical and administrative activities. The maintenance department must provide as nearly trouble-free operation as is humanly possible. Doing so requires skill of a sort not usually found in a handy man. The complexities of air conditioning, automatic elevators, electric intercommunicating systems, and similar equipment are far beyond the capabilities of any except a trained engineer.

The purpose of the hospital plant maintenance and repair department is to assure delivery of light, heat, and refrigeration; to provide repair and maintenance services necessary for the care of hospital facilities; and to maintain a pleasant and comfortable physical environment for patients, employees, medical staff, and the general public. The work includes the upkeep and repair of buildings and grounds, and of those items of equipment which are not the responsibility of individual departments.

The objectives of the plant department may be summarized as follows:

• To maintain the physical plant of the hospital satisfactorily and in accordance with the established policies of the administration.

• To provide operating services required by the hospital departments with a degree of reliability consistent with economy.

• To operate successfully within a sound budget predicated upon known objectives and work loads.

• To establish and maintain a physical plant organization with economy of staff consistent with these objectives and policies.

Maintenance of buildings, grounds, and equipment requires carpentry, painting, plumbing, plastering, welding, and many other services. The person in charge of the engineering and maintenance functions of the physical plant is also generally responsible for establishing technical procedures, advising top management on matters pertaining to repairs, utilities, and building construction, and supervising and co-ordinating improvements in the hospital plant and grounds.

To be qualified, the plant engineer should be well-versed in steam equipment and its operation, in electrical systems, in elevators, and in plumbing, painting, carpentry, and allied fields. Some equipment, such as x-ray facilities, will require the special services of people trained in a particular field. But the main problem facing the plant engineer is primarily that of electrical and mechanical maintenance. Because of his extreme importance to the hospital, before he is employed he should be carefully screened for his over-all knowledge in the various areas necessary to keep the hospital and its vast array of mechanical and electrical gadgets in prime operation.

The importance of the plant engineer should be recognized in the total organizational set-up of the hospital. He should certainly have equal status with other department heads. He should be consulted before any alterations or any major changes in the existing structure are planned. Any moving of equipment that would involve the relocation of electrical outlets or of water, air, or oxygen supply lines is in the plant engineer's province and should receive his careful consideration.

(Continued on page 56)

*Director of Research, Project W-34, U. S. Public Health Service, San Diego, Calif.

TYPICAL WORK ORDER

DATE _____ | PRIORITY ☐A ☐B ☐C ☐D | NUMBER _____

ASSIGN TO:

- ☐ CABINET AND CARPENTER
- ☐ COMMUNICATIONS
- ☐ ELECTRICAL
- ☐ FURNITURE
- ☐ GROUNDS
- ☐ HEAT AND POWER
- ☐ INSIDE MACHINE
- ☐ LOCK AND KEY
- ☐ OUTSIDE MACHINE
- ☐ PAINT
- ☐ PLAN. AND ENGR.
- ☐ PLUMBING
- ☐ REFRIGERATION
- ☐ STEAM
- ☐ UTILITY

COPIES TO:

- ☐ SUPT. CONSTR. AND MAINT.
- ☐ SUPT. OPER. SERV.
- ☐ SUPT. PLAN. AND ENGR.
- ☐ SUPT. STORES

CHARGE TO ACCOUNT _____

REQUESTED BY _____

SCHEDULED COMPLETION BY _____

DESCRIPTION OF WORK TO BE PERFORMED:

INSTRUCTIONS FOR USING THIS FORM:

SPECIFICATIONS: 8½" x 11" pads. Form made out in triplicate with second carbon on top 7" x 8½" section only (through approved). Add extra "short form" copies for each shop involved.

DISPOSITION OF COPIES:

ORIGINAL: Held in director's office in "active" file until job completed. Labor costs recorded daily. Total labor and material recorded when job is complete. Used to prepare interdepartmental transfer vouchers or to break down physical plant expenditures by accounts.

DUPLICATE: Forwarded to stores clerk. Held in "active" file until job completed. Requisitions and purchase orders attached as filled. Total recorded when job is complete. Forwarded to director's office for posting to original.

TRIPLICATE: One for each shop foreman forwarded as authorization for work. Used by workman to draw material. (Material used from shop stock entered on back. Forwarded when complete to storeroom to be posted on duplicate.) Filed by shop when completed.

APPROVED _____ | COMPLETED _____ SIGNATURE _____

ESTIMATED COST:

LABOR $ _____

MATERIAL $ _____

TOTAL $ _____

ACTUAL COST:

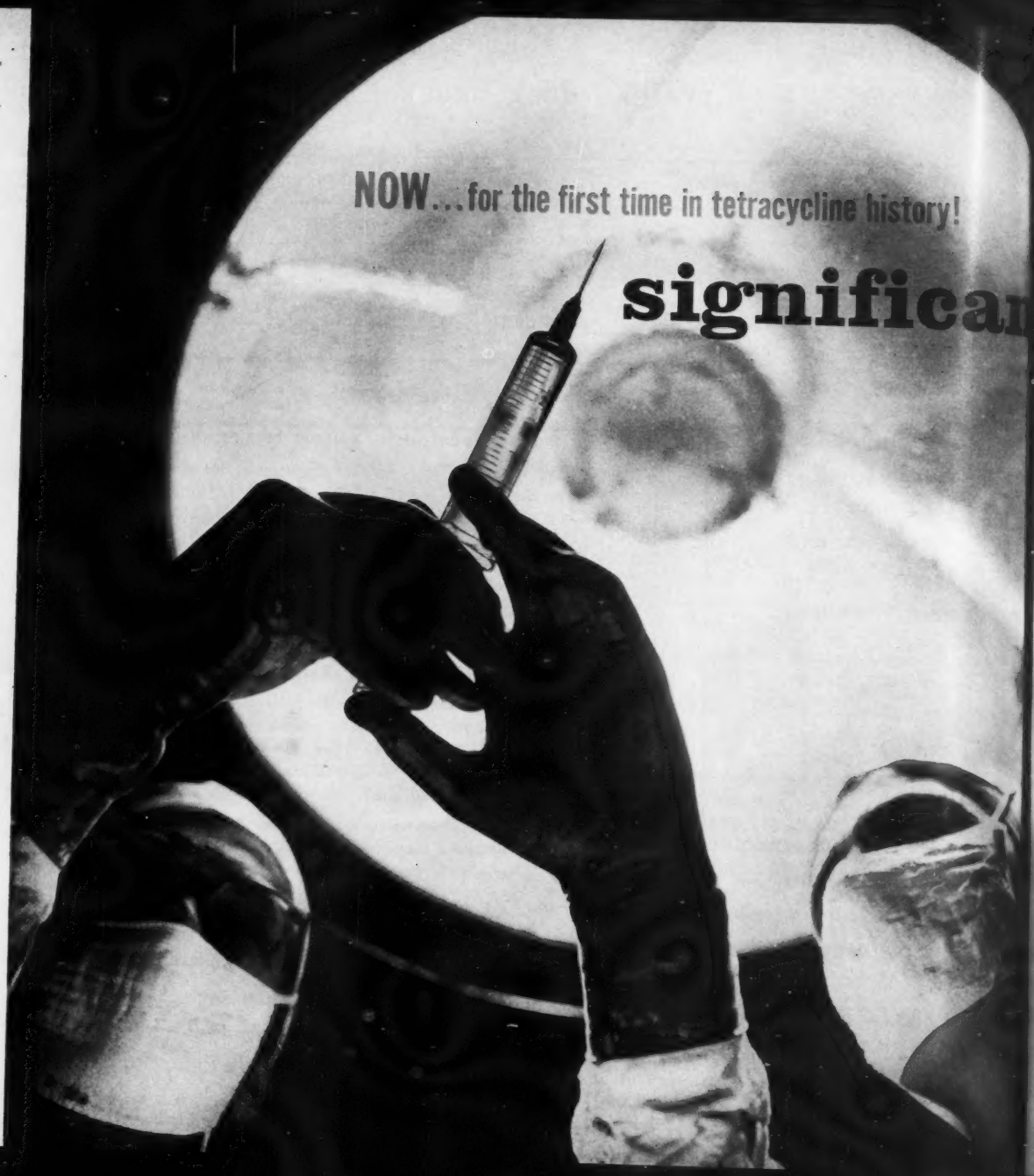
LABOR $ _____

MATERIAL $ _____

TOTAL $ _____

REMARKS:

Attach all material requisitions to stores copy, and record daily labor cost on the back of the original.



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TETREX Intramuscular '250' can be reconstituted for injection by adding 1.6 cc. of sterile distilled water or normal saline, to make a total injection volume of 2.0 cc. When the entire 250 mg. are to be injected, and minimal volume is desired, as little as 1.0 cc. of diluent need be used. (Full instructions for administration and dosage for adults and children, accompany packaged vial.)

Each one-dose vial of TETREX Intramuscular '250' contains:

TETREX (tetracycline phosphate complex) (tetracycline HCl activity).....**250 mg.**

Xylocaine* hydrochloride ..... **40 mg.**

plus ascorbic acid 300 mg. and magnesium chloride 46 mg. as buffering agents.

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SUPPLY: Single-dose vials containing TETREX – tetracycline phosphate complex – each equivalent to 250 mg. tetracycline HCl activity. Also available in 100-mg. single-dose vials.

NTRAMUSCULAR '250' WITH XYLOCAINE

STOL LABORATORIES INC., SYRACUSE, NEW YORK

(Continued from page 52)

DEPARTMENT ORGANIZATION

The organization of the physical plant department depends, in part, upon administrative policy. It depends to the greatest extent, however, upon plant size. The most frequently encountered reasons for organizational problems are these:

- **Failure to include all physical plant functions under one competent plant engineer, who reports to the hospital administrator or an assistant administrator for plant and services. These functions include building maintenance and repair, grounds care, utilities and plant operations, and a major responsibility in the planning for new construction.**
- **Inclusion of nonrelated functions, such as purchasing, in the plant organization.**
- **Duplication of maintenance shops and staffs in different areas of the hospital complex.**
- **Division of responsibility for related functions among subdivisions of the plant organization.**
- **Provision of either excessive or inadequate administrative and supervisory personnel.**
- **Failure of the department to function as organized.**

BUILDING MAINTENANCE

The term "building maintenance," as generally used, is more inclusive than it first appears. The broad interpretation includes repair of buildings; repair of furniture and equipment; provision of minor alterations and improvements in the building.

For budget control and work scheduling purposes, building maintenance usually is classified in the following manner:

1. General or routine maintenance—involves (a) minor repairs for maintenance, and (b) unanticipated emergency maintenance. Routine maintenance includes repairs to pipes, faucets, locks, door closers, and light switches, and correction of malfunctioning air-conditioning units and failures in power equipment. These problems, which usually require immediate action, most often are brought to the attention of the maintenance staff by a telephone call, or by an informal note from operating personnel or a custodian.

2. Scheduled maintenance and minor improvements—include those items of limited scope which may be anticipated, and thus scheduled in advance or deferred in their accomplishment. This category includes maintenance items discovered in routine inspection programs, and involves such work as painting, annual heating and power plant overhauls, servicing of compressors and refrigeration equipment, and minor alterations and improvements in existing plant facilities and equipment. It is customary to place an upper dollar limit on the individual job which can be covered in this category.

3. Extraordinary maintenance—covers major projects which exceed the upper dollar limit for scheduled maintenance. These projects usually are included in the budget as line items. The category covers such items as replacement of a roof, complete rehabilitation of the building, or replacement of major items of equipment in the building.

4. Major alterations and improvements—include changes in existing plant facilities which exceed the upper dollar limit placed on minor improvements. These also are usually included in the budget as line items. This category covers such items as installing major air conditioning units.

MAINTENANCE MANAGEMENT

Maintenance management connotes more than just work scheduling. It includes a methodical analysis of what work needs to be done, timely accomplishment of the work according to a priority schedule, control of labor and materials expended to insure maximum efficiency, and adequate reporting to administrative management.

Nine steps are basic to effective maintenance management.

1. Use a work order system.

The work order is the mainstay of maintenance management. First, it fills the definite need for a formal method of instructing the craftsmen what is to be done, where it is to be done, how it is to be done, and when it is to be done. Second, good maintenance management requires a periodic summary report to the administration. Work orders, recording labor and material costs, form the basis for these reports.

2. Establish a system of priorities.

The basic rules to be followed are: (a) question every large, high-cost job; (b) throw out all unnecessary jobs; and (c) do the rest promptly and well.

Priorities for jobs should be determined on the basis of whether—

—failure to correct would result in serious additional damage;

—the deficiency is increasing in magnitude and scope;

—correction of the deficiency would produce significant operating economies;

—the project must be completed before a specified date to avoid inconvenience to the requesting activity, or to realize the purpose of the request;

—the deficiency produces an unsightly appearance and is causing complaints.

3. Establish an annual inspection program.

The entire physical plant should be inspected annually by competent engineers and craftsmen, and, in individual departments, in company with a represenative from those departments. The inspection should be made before the preparation of the annual

(Continued on page 59)

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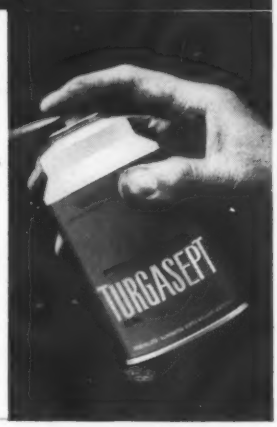

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CONCENTRATE: 2 oz. sealed packet—to 1 gal. hot water—makes sufficient solution for washing floors, walls, etc.

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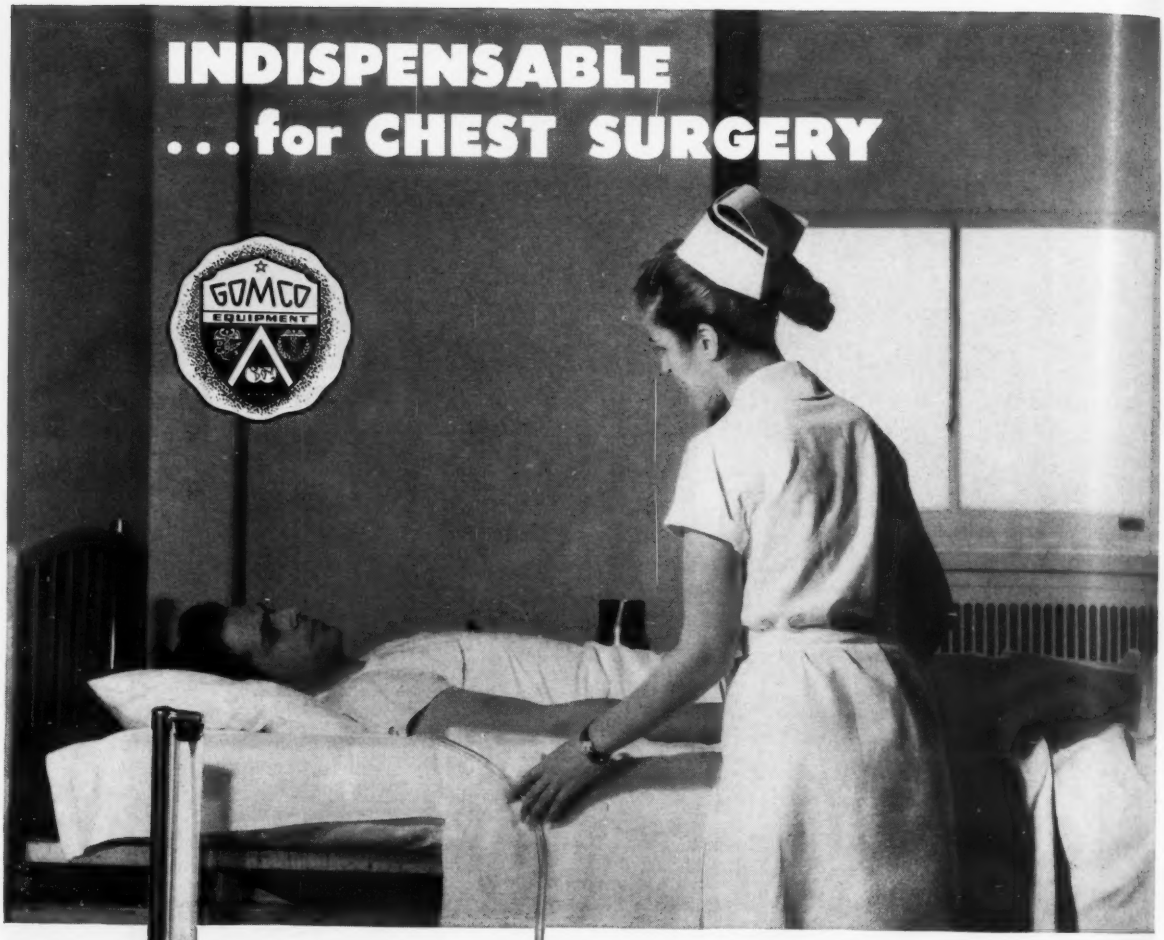

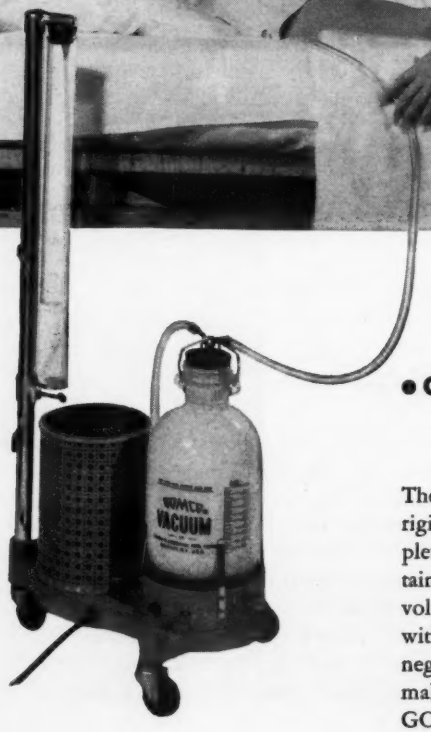

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(Continued from page 56)

budget in order to determine exactly what work needs to be done. So that no item will be overlooked, inspection check-off lists should be used. These lists also constitute a record of work already performed and work to be performed.

4. Analyze and plan jobs.

Each scheduled repair and minor improvement should be carefully analyzed. Although this may be done by the chief engineer or by a foreman, preferably it should be done by a planner and estimator. He should determine exactly what is to be done, and what parts, materials, tools, and equipment will be needed. In addition, a weekly forecast should be made of work to be done. This forecast should be made in agreement with the operating department in case any job should result in an interruption of normal procedures.

A job control board is useful in this planning process. Work backlog is immediately apparent, and it is possible to tell whether any shop has too large or too small a crew for the work to be done. At the end of each day, work for the following day should be scheduled for each shop and workman by the chief engineer and his foremen.

5. Estimate all jobs costing over $50.

Estimates provide a measure of labor effectiveness. By measuring the amounts of time and material actually expended on a job and comparing them with the pre-estimated amounts, labor performance can be evaluated.

6. Provide adequate material control.

This involves establishing maximum and minimum limits for each item in stock. These limits must be adhered to, so that the workmen can be sure that material needed will be on hand.

7. Keep equipment records.

A maintenance and repair record card should be prepared for each major item of equipment. Such a card provides a permanent record of the maintenance performed, and serves as the basis for justifying replacement; also it aids in selection of the most satisfactory type of equipment when more than one type has been used.

8. Set up a preventive maintenance program.

Preventive maintenance permits the performance of work when it is convenient, instead of when a breakdown occurs. Such a program also permits continuous scheduling of manpower, thus reducing to a minimum idle time and overtime. As much as 50 to 75 percent of all maintenance work can be scheduled on a preventive basis. Six steps are required to establish such a program.

A. Make a permanent equipment record card, listing essential name plate data, date of installation, capacity, and similar information.

B. Obtain from each manufacturer catalogs covering repair parts and servicing—generally outlined in detail—with recommended inspection and servicing schedules.

C. Prepare inspection schedules in check-list form.

D. Prepare time standards for inspection and servicing.

E. Develop inspection and servicing routes to be followed by preventive maintenance men.

F. Operate standby equipment frequently, on a regular schedule, to insure that it will be ready for use in an emergency.

9. Analyze performance and costs.

Costs should be accumulated by specific jobs and by cost centers. One example of a cost center is an item of major equipment, as previously mentioned. Other cost centers are individual buildings, heating and refrigeration plants, grounds, and administrative overhead.

The cost of steam per 1,000 pounds, power per kilowatt hour, building maintenance per square foot, and heating per cubic foot also should be computed, as a matter of routine, and should be compared with past performance. This permits the isolation of unwarranted rising costs, and of equipment and buildings requiring excessive maintenance. Unit measures are also essential tools for an intelligent budget process.

RECORDS

The plant engineer should have the floor plan of the hospital and a complete set of working drawings. He should have a complete layout of every water, steam, air, and oxygen line, of telephone wiring, conduit cables, and any other system relating to the mechanical operation of the hospital.

In many hospitals, additions and alterations have resulted in a complex of wires and cables, the original use of which has long been forgotten. The competent plant engineer will have all of these labeled, charted, and broken down into divisions, so that, in the event of trouble or a disruption of service, his department can immediately locate the areas involved and work intelligently toward correction of the difficulty.

He should also have a complete list of fixed equipment, such as boilers, sterilizers, furniture, fire equipment, and electrical systems. This list should include the cost for each item, so that the engineer may prepare an intelligent budget for his department, and also may properly charge the cost of maintenance to the item, as maintenance for it is required.

INVENTORY OF MOVABLE EQUIPMENT

The inventory of movable equipment consists of attaching to every piece of movable equipment, as it comes into the hospital, a metal or plastic tag bearing the name of the institution and a consecutive serial number. This number stays with the

(Continued on next page)

equipment. The tag should be screwed on, or riveted in the case of metal equipment.

If the equipment is assigned to a particular department, it is a simple matter to check the number of the equipment and find out if it has been moved or what has happened to it. Periodic checks should be made under this system to insure that equipment stays in the department for which it was ordered.

Even the smaller community hospitals have many thousands of dollars invested in movable equipment. It frequently disappears or is stored inconveniently. An inventory of movables makes certain that the equipment which the hospital has paid for is rendering the service for which it was intended.

If the maintenance department is properly organized under a plant engineer who has a secretary and a clerk, the inventory of movable equipment can be maintained in this department's office. The maintenance department has more general knowledge of what goes on in the hospital, equipment-wise, than any other department. Hence, this office is the logical place for the inventory.

It should be routine for the maintenance department to receive copies of purchase orders for major equipment that it will be expected to service and maintain. This system enables maintenance to enter in its records the cost, acquisition date, and other data essential to a good cost system.

MAINTENANCE BUDGET

The physical plant represents the major share of the hospital's capital investment. Preservation of this investment is essential to continued, effective operation.

Building maintenance and repair constitutes the largest single item in the buildings and grounds budget. Consequently, this item offers a great opportunity to achieve economy through management controls. At the same time, there is a real temptation to reduce costs beyond a practical point, which results in the plant's being allowed to deteriorate, placing an even greater burden on the budget.

How, then, may the proper amount of money to budget for maintenance be determined? Many systems have been employed from time to time; most frequently, the new figure is the amount budgeted last year plus a little. Another system uses a certain percentage of the previous budget, cost per square foot or cubic foot, and cost per patient day. The difficulty is, of course, that labor and material costs change from year to year, as do such other unit budget items as the hospital census, although not in the same proportion.

Experience indicates that the building replacement value, which reflects these changing conditions, is a sound basis for budgeting. Under this system, the cost of replacing the identical building is computed by the use of building cost indexes, available in publications such as the *Engineering News-Record*. The experience of those who have kept adequate records indicates that maintenance expense bears a definite relation to this replacement cost.

It will be necessary for a particular facility to accumulate its own data, but the following percentages of replacement costs can be used initially as guides.

Type Construction	Maintenance Factor
Wood—frame	1.75-2.00 percent
Masonry—wood	1.30-1.50 percent
Masonry—concrete—steel	1.10-1.25 percent

As an example of how the system works, assume a masonry and steel building was constructed in 1935, at a cost of $1,900,000. The building cost index for the locality in 1935 was 89.0. In 1956, the building cost index for the locality is 242.5. Thus, the replacement cost can be determined this way:

$$\frac{242.5}{89.0} \times \$1{,}900{,}000 = \$4{,}750{,}000$$

The annual maintenance cost in 1956 would be from:

$$.0110 \times \$4{,}750{,}000 = \$52{,}250$$

to

$$.0125 \times \$4{,}750{,}000 = \$59{,}375.$$

This range is a reasonable one. Only a physical inspection and detailed past experience will tell which figure is more nearly correct.

Maintenance cost of distribution systems can be based upon how many thousands of feet are installed; of electrical equipment, upon capacity of kilovolt-amperes installed; and of furniture, upon number of items to be maintained. In each case, past unit cost experience is essential to determine cost factors applicable to the particular item.

TYPICAL WORK ORDER SYSTEM

To evaluate the performance of maintenance personnel, it is essential to accumulate the cost of specific maintenance jobs. To forecast budget requirements intelligently, maintenance costs must be accumulated by specific categories, and by building. And to accumulate these costs, it is necessary to have a work order control system.

Such a system should include two basic procedural arrangements, one for use on routine and emergency jobs associated with specific buildings and the other for specific jobs such as scheduled maintenance, minor alterations, major repairs or renovations, or unusual maintenance operations. These complementary systems are discussed in the following paragraphs.

1. Standing work orders should be written to cover routine and emergency maintenance.

These blanket, or standing, work orders should authorize performance of all routine maintenance

(Continued on page 62)

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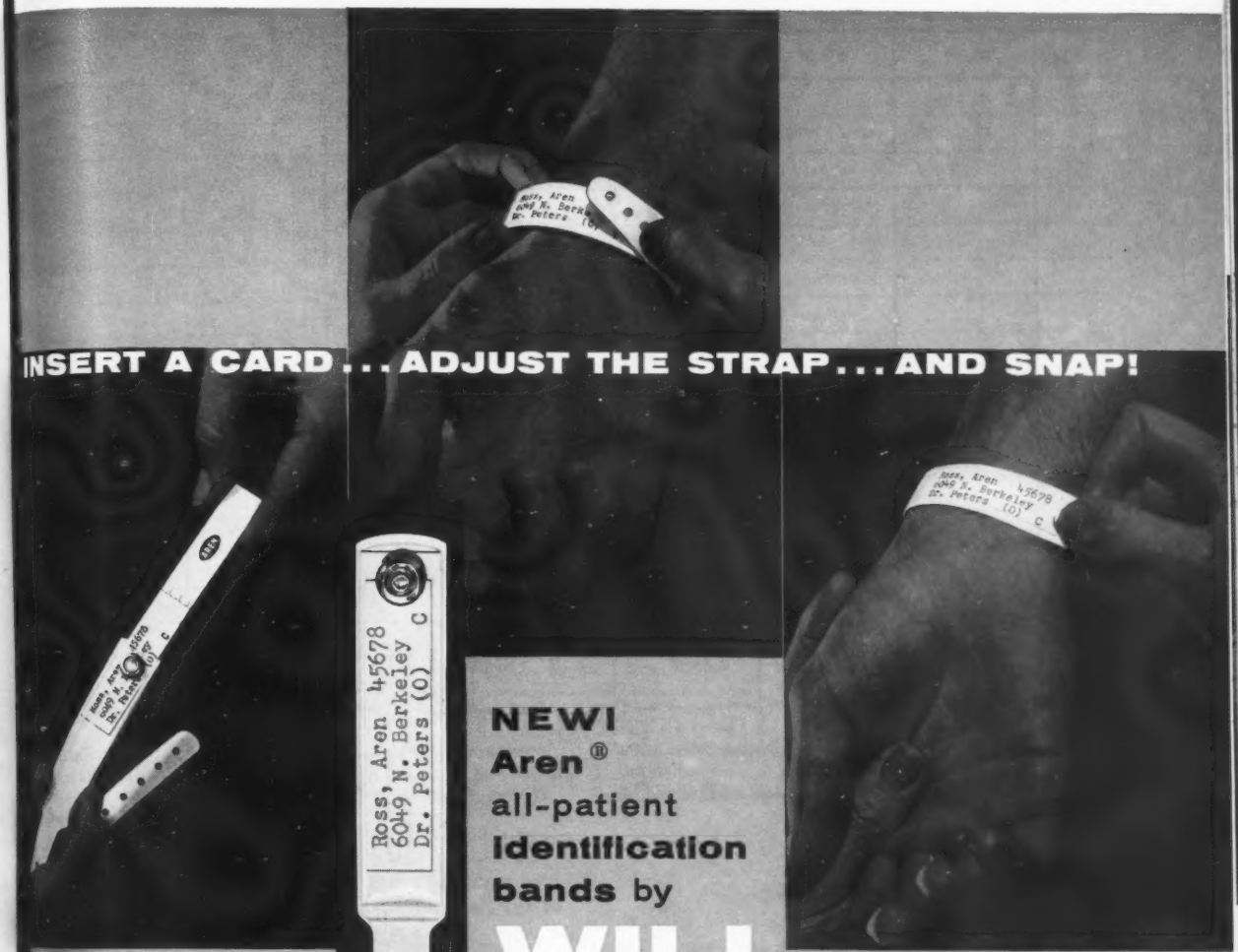

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DAILY LABOR COSTS

DATE	SHOP	SHOP	SHOP	SHOP	SHOP	SHOP	SHOP

Above is example of typical form for recording labor costs, by days, for specific work orders, written to cover scheduled or unusual maintenance, major repairs or renovations, or alterations. This form, printed on reverse side of work order form, can be filled in by maintenance personnel when work is done, then attached to stores requisitions.

PLANT OPERATION

(Continued from page 60)

on a specific building or area during a specified period of time. (Annual or quarterly orders are recommended.) Informal repair tickets chargeable to the standing work order should be issued at the time maintenance is required. From these repair tickets, charges should be posted to the standing work order ledger. The detailed procedure for such orders should be as follows:

A. A standing work order number should be assigned to each building or major area for which costs are to be accumulated. Since standing work orders are issued for recurring-type maintenance, each building should be given the same work order number from year to year.

Under this system, the first 100 work order numbers might be set aside for standing work orders. The first work order issued for a non-routine, specific job would then bear the number 101.

B. When requests for routine maintenance are received by the service desk in the maintenance and repair office, they should be written up on a repair ticket bearing the appropriate work order number. Repair tickets should be prepared in duplicate, in longhand, by a service desk clerk, as received.

C. One copy of the repair ticket should be given to the appropriate worker, and one copy retained by the service desk clerk.

D. The maintenance worker should itemize labor and material costs in the space provided on the back of the repair ticket.

E. Completed repair tickets should be returned to the service desk clerk, who should review and approve each ticket for costs.

F. When labor and material costs have been posted to the standing work order by the work order clerk, the pending copy should be destroyed and the completed copy filed.

Work of this nature generally is handled in the most expedient manner possible and reviewed after completion, not before. Given specific limits and instruction concerning this category of work, the service desk clerk should be entirely capable of segregating those requests which fall in the category of scheduled maintenance and require more formal handling with a specific work order.

2. Specific work orders should be written for scheduled maintenance, major repairs or renovations, alterations, or unusual scheduled maintenance.

Written requests normally should be issued by responsible officers, by the physical plant maintenance engineer, or by the housekeeping department for work requiring specific work orders. Such requests should flow to the service desk clerk, who should be located in the maintenance office. The procedure for specific work orders should be as follows:

(Continued on page 64)

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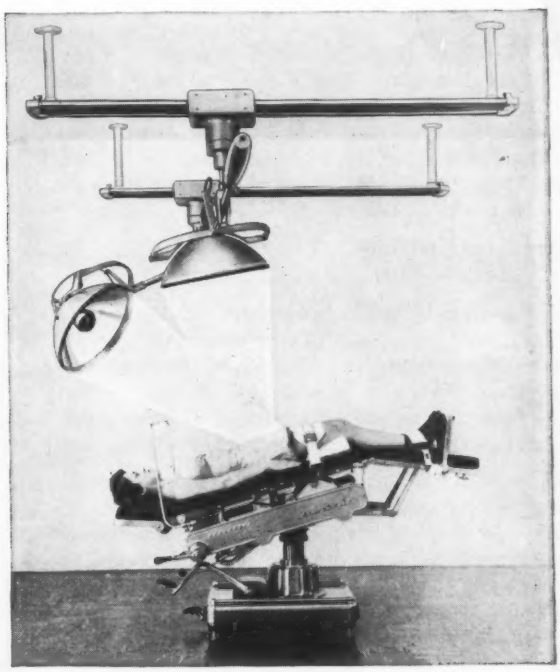

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(Continued from page 62)

A. The request should be submitted on a standard requisition or a work request, with an original and two copies. Departmental requests should be made only when funds have been provided in the budget for such projects.

B. The service desk clerk should assign a requisition number and enter the request in a record book.

C. The request should be forwarded by the service clerk to the comptroller for review, approval, and estimate, and then returned to the service desk.

D. The service clerk should enter the estimated amount to be spent on the original and both copies, then forward the original and one copy to the business office, and one copy to the requesting department or officer.

E. The business office should charge the appropriate account, return the original to the service clerk, and retain one copy. If funds are not available for the proposed job, an appropriate notation should be made on the original, and the requesting department should be notified by the business office.

F. When the original is returned by the business office to the service clerk, she should prepare a specific work order, on a form such as the one shown on page 53.

G. The service clerk should retain the original copy in a pending file and give a copy to the chief of maintenance.

H. The chief of maintenance should review the work order and assign it to a maintenance man. Material should be obtained from stores on a stores requisition. The maintenance man performing the work should enter the labor time on the back of the work order (see page 62), and attach copies of stores requisitions and a list of materials used from shop stocks. Then, he should return the completed work order form to the foreman or the chief of maintenance.

I. The foreman should check the completed work order form and return it to the service clerk.

J. The work order clerk should list all labor time and material required on the original copy, compute total cost, and forward the original to the appropriate superintendent for review and approval. The original should then be returned to the work order clerk for placement in a completed file.

K. When the cost is to be charged to a department, an interdepartmental transfer voucher should be prepared and the original forwarded to the accounting department as a charge for services rendered. Simultaneously, one copy of the voucher should be forwarded to the requesting department, and another copy should be filed with the completed work order file.

Another work order system utilizes a triplicate, pre-numbered set. The order originates in the department requesting service. There should be two types, and preferably, a two-colored set of requisitions. One, which might be red, would be termed a "request for emergency service."

For instance, if an essential piece of equipment breaks down, a telephone call to the plant engineer's office starts maintenance men on their way as soon as possible. This telephone call, however, should be followed up with a regular requisition for service, made out in triplicate, and signed by the department head or someone else authorized to sign the request.

The originating department keeps the original and one copy, and another copy goes to the plant engineer's office. After the work has been done, the plant engineer enters on all copies of the requisition the supplies that have been used, the amount of time spent, and the number of men involved. The original copy is then forwarded to the business office.

The other type of requisition in this system might be termed "elective." Generally, it requires the approval of the administrator or someone authorized by him before the work may proceed. A good budget will provide for minor department alterations, which may be done by the maintenance department at slack times. In this case, when a department is ready to have the work proceed, the requisition is sent to the administrator's office for approval, then is forwarded to the plant engineer's office. After approval, however, the work may proceed under the same routine as that outlined for the emergency work order.

In emergency breakdowns of hospital equipment, securing approval before repair work is started is almost impossible. However, the optional type of repair or alteration should always have the approval of the administrator or someone designated by him before the work is actually started or any materials are purchased. The emergency requisition would probably be charged against the maintenance and operating item in the hospital budget.

ROUTINE WORK SCHEDULE

The following is an example of a routine work schedule.

Monday

1. Check all refrigeration and condensing units.
2. Check all refrigerator boxes and vaults in main kitchen.
3. Check morgue air-conditioning unit.
4. Clean all P.F. ♯4 filters, spray pans, screens, and nozzles.
5. Check all electrostatic and fresh-air filters.
6. Drain water from the blow-off on the power air compressor.
7. Check all stair and exit lights.

Tuesday

1. Check all fan bearings and belts. (Check with foreman as to the oiling of any fan bearings and the tightening of belts.)
2. Clean C.F. ♯7 filters if necessary.
3. Clean and service pump on hot-water system.

(Continued on page 65)

Another New Private Room Grouping in Teakwood Grain Farlite

(designed by Raymond Loewy)

• Here is another beautiful private room featuring the new Hill-Rom No. 8500 Grouping designed by Raymond Loewy and finished in No. 85 Teakwood Grain Farlite. The bed, beside cabinet and straight chair all share in the beauty and utility of this high pressure laminated plastic, combined with Satin Stainless and Loewy Charcoal.

As in all Hill-Rom designs, every item in this grouping has been scaled down to appropriate size for today's small hospital rooms. No longer is it necessary to crowd these small rooms with furniture designed for the larger rooms of several years ago—another "Hill-Rom First."

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8500
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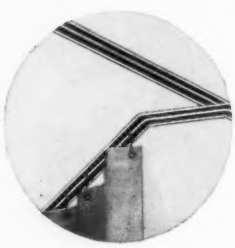

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by either patient or nurse

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HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

PLANT OPERATION

(Continued from page 64)

4. Switch pumps on house tanks, clean and service pumps and motors.
5. Check all equipment in machine rooms.
6. Check all air-conditioning units.
7. Check stills in central supply and laboratory.

Wednesday

1. Check all sewage and sump pumps.
2. Change recorder charts.
3. Check ice machines.
4. Check all spray pumps and air supply units.
5. Check all electrostatic and fresh-air filters.
6. Check refrigeration condensing units in all areas but kitchen.
7. Clean any dirty filters that have been taken from fans.

Thursday

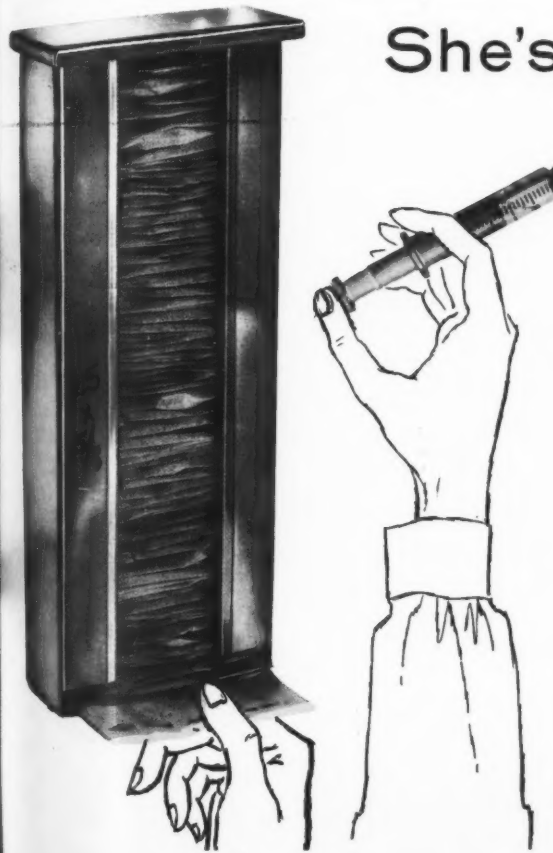
1. Check sewage and sump pumps, all buildings.
2. Check all flake ice machines.
3. Check all electrostatic and fresh-air filters.
4. Check all refrigerator vaults and boxes in main kitchen and defrost if necessary.
5. Check refrigeration in pharmacy (vault and boxes) OPD basement.
6. Check walk-in unit in kitchen.
7. Check all kitchen equipment.
8. Run emergency generators.
9. Check all operating-room lights.
10. Check main switch room; clean if necessary.
11. Check all drinking water fountains and their flow and operation.

CONTRACTUAL SERVICES

By and large, the hospital maintenance and repair staff can perform the routine maintenance work more effectively and economically than can outside contractors. In some cases, the staff can even perform the larger, non-routine jobs more effectively. Assistance of contractors is very helpful, however, if used to back up the staff on jobs that would upset the routine of normal maintenance work, such as major equipment installations, new construction, and large emergency jobs.

The decision to use a contractor should be based upon a comparison between an estimate made by the staff and bids received. The estimate must be made in any case to determine cost and fund availability. Only by estimating can staff labor effectiveness be measured, the most economical method of accomplishment be determined, and a fair contract price be established.

Part II of this article, discussing selection and maintenance of equipment for utility services in the hospital, will appear in the July issue. This two-part article is the third in the current series on hospital service departments. Dietary and food services were covered in the March issue, laundry operations in the April and May issues. Future articles will take up housekeeping, and purchasing and stores.



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*Koch, R., and Donnell, G.: California Med. 87:313, 1957.

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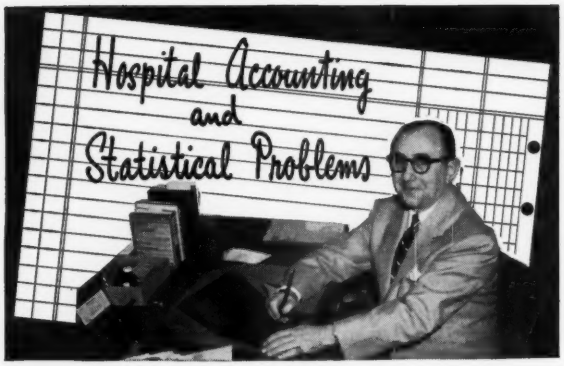

By David H. Tarlow, C.P.A.
Senior Partner, D. H. Tarlow & Co.
Hospital Accountants and Auditors, New York City

Q. When patients are discharged from our hospital and their bills have not been paid, we ask them to sign a note for the amount due.

This procedure obtains in all instances other than welfare cases in which we know the patient is unable to pay for hospital care. At the last meeting of the finance committee of the Board of Trustees, the question was raised whether such items may be included in patients' accounts receivable on the balance sheet presentation. Any assistance you can give us in this matter would be appreciated.

A. We would recommend that you establish a separate category for notes receivable—patients. In our opinion, the establishment of a reserve for uncollectible notes would have a different base than the normal run of accounts receivable.

Further, we have found that, in some areas, such items are discounted at the local bank, with the collection procedures being taken over by the bank. Greater facility in maintaining control would prevail, therefore, if patients' accounts receivable were segregated from patients' notes receivable on the books of account.

* * * * *

Q. In establishing a chart of accounts, should separate provision be made for fees paid to the radiologist and pathologist, or are such fees normally included in the salaries of the x-ray department and laboratory?

A. If the radiologist and pathologist are paid on a salary basis, then their salaries are properly included in the respective salary accounts of the related departments. However, if payments to these individuals are based on a percentage of either gross or net, then such payments should be segregated from the salary account and shown as fees—radiologist; fees—pathologist.

According to information received from the social security office, if the major part of the physician's income is obtained from the hospital, he may be included in social security coverage. You may wish to review this further with the respective individuals and local counsel.

* * * * *

Q. In setting up an aging of accounts receivable, what categories should we use? Also, what further analysis would you recommend for guidance in setting up reserves for uncollectible accounts?

A. Accounts are usually "aged" according to discharge date. We recommend three categories: 30 days, 60 days, and 90 days and over. The subheadings we use are Blue Cross, Other Insurance, Workmen's Compensation or Industrial Commission, Welfare-Approved, Welfare-Not Approved, and All Others. In some states, in which liens in accident cases are honored by the courts in the settlement of negligence claims, a further section is established to cover this type of case.

When the collectibility of outstanding sums in these categories can be observed for a complete fiscal period, the ratio of the reserve to be established can be gauged more accurately.

* * * * *

Q. When our budget was presented to the local community chest agency, a discussion arose regarding the amount of free care given by the hospital. A specific question was asked concerning how many days of free care we gave during the past year. I referred the group to the amount of allowances and bad debts, but since the sum of these two items was much greater than the net operating deficit of the hospital, I was asked to seek further data on how days of free care was computed. May we have your opinion on this subject?

A. As a rule, it appears that free care is recognized only in the wards and in the clinics, since it is assumed that private and semiprivate patients can pay for hospital services rendered. We have found the following formula to be used and accepted in establishing days of free care for a particular fiscal period:

Ward combined income	$250,000
Divided by average ward cost per day	$25
Equals the number of days paid for at cost	10,000 days
Total ward days	12,000 days
Paid days subtracted from total ward days equals the free days for which nothing was paid	2,000 days

By this method, part-paid days as well as totally free days are recognized. In teaching hospitals, almost all ward patients get some free care even though they may pay full rates. This is due to the fact that ward charges are often lower than ward costs, while private and semiprivate charges are slightly higher than cost in order to obtain budgetary equilibrium.

If you do not have segregation of costs among the respective categories of private, semiprivate, and ward, then you would use the total income, total cost, and total days of care as a basis for days of free care given at your institution in all categories.

Review of Hospital Law Suits

When Is Drug 'Adulterated'?

By Leo Parker
Attorney at Law

A higher court recently rendered an important decision to the effect that if a substance contains a virus too small to be seen by use of a microscope, it is not "adulterated."

In Merck & Co., Inc. v. Kidd, 242 Fed. Rep. (2d) 592, a state law was litigated which provides that a drug is adulterated if it consists in whole or in part of any filthy, putrid, or decomposed substance.

The testimony showed that Kidd injured his leg. He was taken in a state of shock to a hospital. There his wife signed a "consent" to any medical or surgical procedure the surgeon or physician in charge of his case might deem necessary. Because of Kidd's condition, the hospital's resident surgeon administered a quantity of blood plasma before performing an emergency operation.

Kidd made a normal recovery and was discharged from the hospital about a week later. About two months later he became afflicted with jaundice, and his condition was diagnosed as probably homologous serum hepatitis. He was confined to a hospital for several days, and to his home during a long period of convalescence.

Kidd sued the manufacturer of the plasma for heavy damages. During the trial it was contended that the powdered plasma administered to Kidd contained a virus which violated the abovementioned state law, thereby rendering the manufacturer liable.

The higher court refused to hold that Kidd was entitled to damages, and said:

"The fact that hepatitis virus is injurious is clearly irrevelant to the question of whether or not it is filthy . . . A virus which cannot be seen even with the most powerful microscope, and the presence of which cannot be known at all except for its ultimate result, is not a filthy substance within the intendment of the statute."

The court went on to explain that the manufacturing process involves pooling the blood from a substantial number of donors and then processing the pooled blood so as to form the dried plasma. If the blood from a single donor contains the virus of serum hepatitis, there is a risk that a patient to whom the product is later administered may develop the disease. Despite every effort to screen the donors, it is recognized that the possibility that the hepatitis virus may be present in dried plasma cannot be completely obviated.

Moreover, if the virus is present, it cannot be discovered by microscopic examination or by any other test known to medical science. It cannot be removed nor destroyed by any known method which does not also destroy the utility of the plasma. The only known way to determine whether the virus is present in any given lot of plasma is to give the plasma to a human volunteer and await developments.

The court said further:

"The appellee's theory was that the plasma in question was adulterated because the virus which it contained was a filthy substance. The effect of evidence was inconclusive, except to establish that there is no medical or scientific definition of the term."

LAWFUL DUTY OF CORONER

A hospital official asks: "Can we lawfully request a coroner to make an inquest on a body, and must the county or city pay the bill? Or if we make the request is our hospital liable for payment of the coroner's fee?"

A few weeks ago a higher court held that the function of the coroner always has been to aid in the administration of criminal justice by inquiring into the circumstances of violent or suspicious deaths. Also, the object of an inquest always has been to obtain information as to whether death was caused by some criminal act. This court held that a city need not pay for other inquests. Hence, if a hospital official makes a request for any ordinary inquest, the hospital is liable for payment of the coroner's fee.

In City of Ashland v. Miller, Coroner, 783 S. W. (2d) 195, it was disclosed that Miller was requested to make 43 inquests. In subsequent litigation the higher court held the city liable for payment of fees to the coroner in only two cases. The court said:

"The number of inquests in which the City has refused to pay the inquest fee is 43. Twenty-nine of the deaths were from 'heart attack' or 'coronary occlusion'; two were from cerebral hemorrhage; two from pneumonia; one from malnutrition; and nine from 'natural causes.' In only two of the deaths was there any suggestion that the circumstances of the death were peculiar or suspicious. In these two cases we think the coroner was justified in holding an inquest and is entitled to his fee. In the other 41 cases no one even intimated that there was any reason to suspect crime, violence or other unnatural cause of death."

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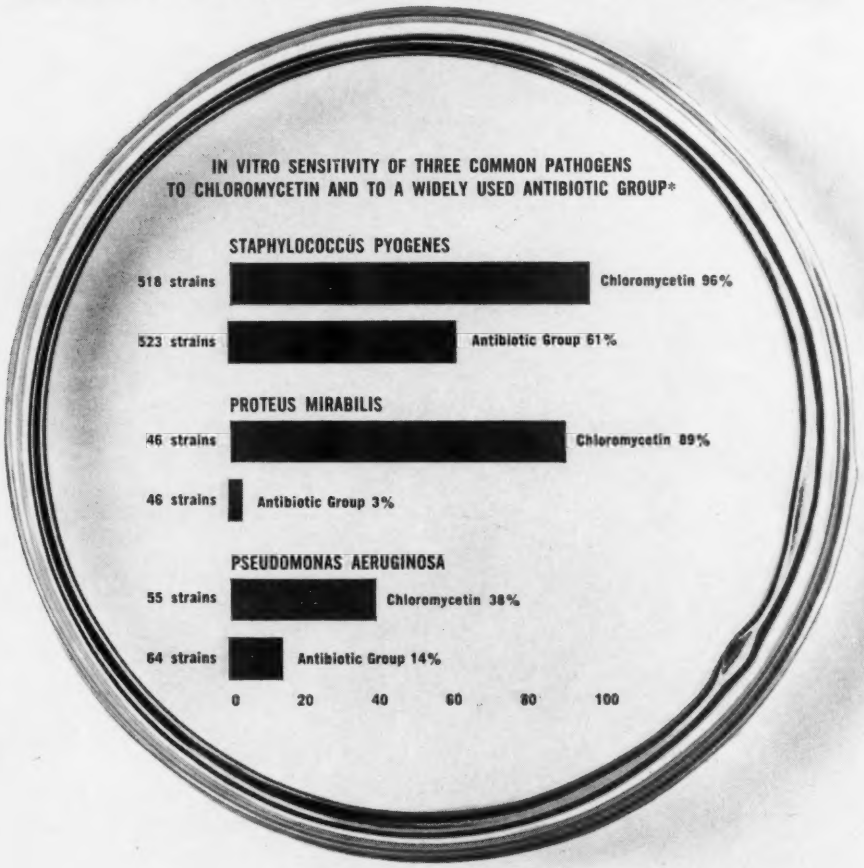

*Adapted from Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844 (Nov. 1) 1957.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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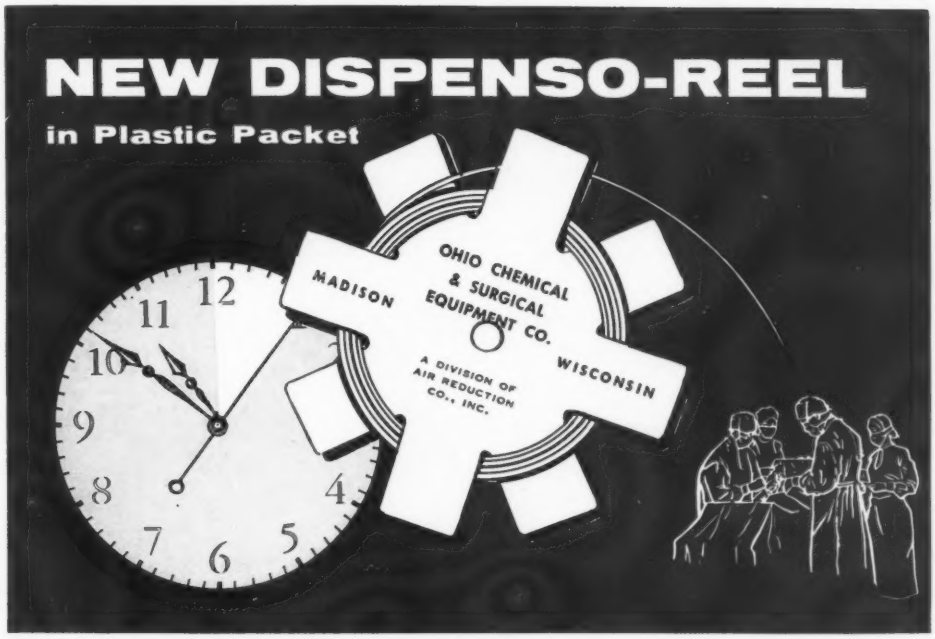
NEW DISPENSO-REEL

in Plastic Packet



for swifter, more efficient handling of

OHIO SURGICAL SUTURES

SIMPLIFIED SUTURE HANDLING

In a few seconds you snip open the plastic packet — remove the suture — and in one continuous movement *spin* it off the Dispenso-reel. Pre-cut lengths are ready for instant use. *No unraveling — no kinking!*

"Service is Ohio Chemical's Most Important Commodity!"

For our new 28-page catalog No. 4708 on sutures and needles, write Dept. HT-6.

SUTURE-NEEDLE COMBINATIONS

Dispenso-reels also keep suture-needle combinations in perfect condition. Needles are held securely. They cannot cut sutures or puncture plastic packet. *No rubbing or movement can dull sharpness of needles.*

LIGATURE DISPENSO-REEL CASE

This lightweight stainless steel case makes ligating simpler and faster. It eliminates tight-roll. Bulk has been reduced. A quick glance identifies the suture *while it is still in the case.*

OHIO

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
MADISON 10, WISCONSIN

Ohio Chemical Pacific Company, Berkeley 10, Calif.
Ohio Chemical Canada Limited, Toronto 2, Ontario
Airco Company International, New York 17, N. Y.
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(All Divisions or Subsidiaries of Air Reduction Company, Incorporated)

in these conditions *peritonitis, mixed infections of the urinary tract, as a supportive measure in surgery, and in selected cases of bacterial endocarditis*

the combination *of penicillin and dihydrostreptomycin is*

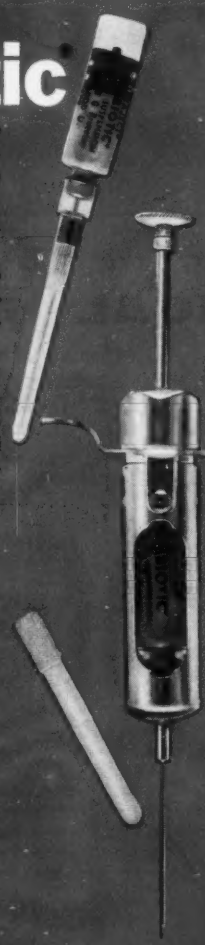
therapy of choice *One injection from one vial*

Combiotic®

COMBIOTIC P-S (DRY POWDER) 1.0 Gm. Formula: 300,000 units penicillin G procaine crystalline, 100,000 units penicillin G potassium crystalline, 1.0 Gm. dihydrostreptomycin sulfate, per dose.

COMBIOTIC P-S (DRY POWDER) 0.5 Gm. Formula: same penicillin content as above, but with 0.5 Gm. dihydrostreptomycin sulfate per dose.

COMBIOTIC AQUEOUS SUSPENSION (ready to inject) in five-dose "drain-clear" (10 cc.) vials, 400,000 units penicillin G procaine crystalline and 0.5 Gm. dihydrostreptomycin sulfate, in each 2 cc. dose.



Combiotic Aqueous Suspension also available in one injection from one cartridge

Steraject®

single-dose disposable cartridge with sterile needle attached — use and dispose — eliminates sterilization, measuring, assembly, breakage

Pfizer injectables available in single-dose disposable cartridges:

PENICILLIN G PROCAINE CRYSTALLINE IN AQUEOUS SUSPENSION, 300,000; 600,000 and 1,000,000 units.

COMBIOTIC AQUEOUS SUSPENSION, 400,000 units penicillin G procaine crystalline plus 0.5 Gm. dihydrostreptomycin.

STREPTOMYCIN SULFATE SOLUTION, 1 Gm.

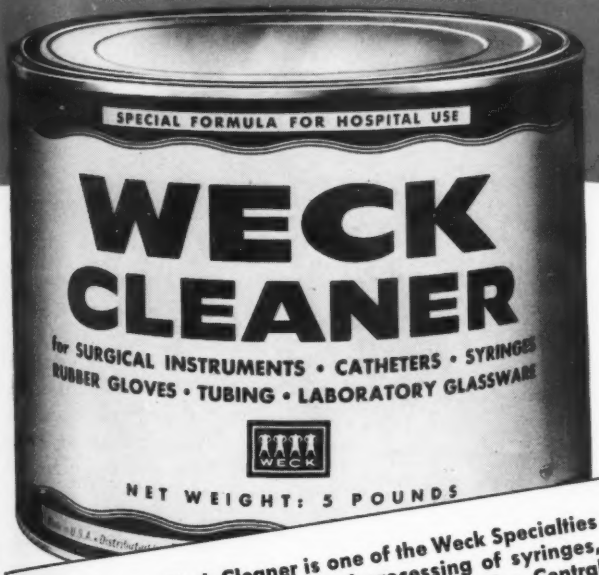
DIHYDROSTREPTOMYCIN SULFATE SOLUTION, 1 Gm.

(smaller, 22-gauge needle for most dosage forms minimizes injection pain)

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

"Now-at last!

we've found a cleaner made especially for surgical instruments. *It's wonderful!"*



Free Weck Cleaner is one of the Weck Specialties for the handling and processing of syringes, needles, catheters, instruments, etc. for Central Supply Service. Weck has prepared a special 8-page brochure which fully explains and illustrates this revolutionary new system. For your copy, just write to Weck.

OF COURSE IT'S WONDERFUL!

It's the *only* instrument cleaner made by an instrument manufacturer.

Weck Cleaner not only cleans more effectively, but it actually *goes twice as far!* You need only ½ ounce—instead of the usual one ounce—to the gallon. One 5 lb. can makes 160 gallons of cleaning solution. This, *by actual hospital test*, is enough to clean 36,000 instruments, or all the instruments needed in 565 average operations. An entire laparotomy set costs less than 1¢ to clean with this "miracle" cleaner. The special "penetrating" action of Weck Cleaner removes all soils from metal and glass by soaking—no scrubbing is needed—yet Weck Cleaner will not corrode metal, etch glass or deteriorate rubber, and is completely safe for hands. Weck Cleaner is also ideally suited for use in the new ultrasonic washers.

Send for FREE sample of WECK Cleaner

WECK

68 years of knowing how

EDWARD WECK & CO., INC. 135 Johnson Street, Brooklyn 1, N. Y.

WECK

Manufacturers of Surgical Instruments • Hospital Supplies • Instrument Repairing

Personally Speaking

Brian Adlington—has been appointed administrative assistant in charge of purchasing, Cedars of Lebanon Hospital, Los Angeles. Previously he was assistant administrator and purchasing agent, St. Luke's Hospital, Spokane, Wash.

Another appointment at Cedars of Lebanon is that of **Mrs. Mary Scales** as coordinator of volunteers. She was formerly director of recreation, VA Hospital, Long Beach, Calif.

James D. Anderson—has been named assistant director, Lutheran Deaconess Home and Hospital, Chicago.

E. Dwight Barnett M.D. — administrator, Palo Alto (Calif.) Hospital, has been named director of the Palo Alto-Stanford Hospital Center, part of the Stanford University Medical Center now being built on the school's Palo Alto campus. He will direct both hospitals after the center opens. Dr. Barnett has also been appointed professor of hospital administration, Stanford University School of Medicine.

Before coming to Palo Alto, Dr. Barnett was professor, and director, Institute of Administrative Medicine, Columbia University School of Public Health and Administrative Medicine, New York City. Prior to that, he headed Harper Hospital, Detroit.

Mrs. Hazelle Bertoglio—has resigned as administrator, San Gorgonio Pass Memorial Hospital, Banning, Calif.

Eugene Bevilacqua — has been named administrative assistant, Allegheny Valley Hospital, Tarentum, Pa. He was previously in charge of personnel and purchasing, Montefiore Hospital, Pittsburgh, Pa.

Ladislaus F. Grapski (r.), recently appointed director of the University of Maryland's University Hospital, Baltimore, receives congratulations from his predecessor, Clifford Blitch, M.D. Dr. Blitch, director of the hospital since 1954, resigned to enter private practice in Florida. Mr. Grapski had been associate director, and assistant secretary to the board of trustees, Johns Hopkins Hospital, Baltimore, since 1951. Prior to that, he was director, Loyola University Hospital, and assistant dean, Stritch School of Medicine, Loyola University, Chicago.

Gwendolyn Biggerstaff—has been appointed chief dietitian, Kennestone Hospital, Marietta, Ga. She was previously coordinator of the program for food service supervisor training for smaller hospitals, Georgia Department of Public Health. **Betty Ligon**, Murray, Ky., will succeed her in that position.

Another appointment at Kennestone Hospital is that of **L. F. Swinger** as administrative assistant.

George M. Brewer—has been named administrator, Louisville (Ky.) General Hospital. He succeeds **R. Edwin Hawkins, Jr.**, who resigned to become administrator of a new hospital near Palo Alto, Calif.

Mr. Brewer was formerly assistant administrator, Presbyterian Hospital Center, Albuquerque, N. Mex.

Paul J. Connor, Jr.—has been named director, St. John's Episcopal Hospital, Brooklyn, N. Y. He was formerly associate director, Rockford (Ill.) Memorial Hospital.

Gerald C. Crary—has resigned as administrator, Scripps Memorial Hospital, La Jolla, Calif., to become executive manager, San Diego, (Calif.) Convention and Tourist Bureau. **Fred W. Trader, Jr.**, former assistant administrator at Scripps, has been appointed acting administrator.

James B. Dallas—has been appointed personnel director, and **Joseph S. Haas**, building superintendent, Tampa (Fla.) General Hospital.

Harry Davis—has been named administrator, Simpson County Hospital, now under construction in Mendenhall, Miss. **Tom Logue** has been appointed assistant administrator.

Mr. Davis is presently administrator, Montfort Jones Memorial Hospital, Kosciusko, Miss., and

(Continued on page 138)

now

STERILE PACKAGED

BARDEX® FOLEY CATHETERS

READY FOR INSTANT USE
WITHOUT PROCESSING OR AUTOCLAVING

Saves time, labor and nuisance—no delays for processing and autoclaving, no problem of trying to anticipate and process in advance the sizes that may be needed. No waits at time of emergency!

Saves money—eliminates the costly steps of processing and sterilizing—gives a *known fixed* catheter cost.

Convenient—simplifies the catheter inventory control problem for Central Supply. Requisitions can be filled *at once*—the right size catheter, easy to open, sterile, ready for instant use.

Write for illustrated brochure . . .

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581

AN IMPORTANT MONEY-SAVING ANNOUNCEMENT FOR HOSPITALS...

Now, in a sweeping move to reduce hospital costs substantially and provide faster, more efficient service, the Surgical Products Division, American Cyanamid Company, inaugurates a revolutionary DIRECT-PURCHASE PLAN!

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AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
NEW YORK, N. Y.

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PRODUCERS OF DAVIS & GECK BRAND SUTURES AND VIM® BRAND HYPODERMIC SYRINGES AND NEEDLES.
DISTRIBUTED IN CANADA BY:
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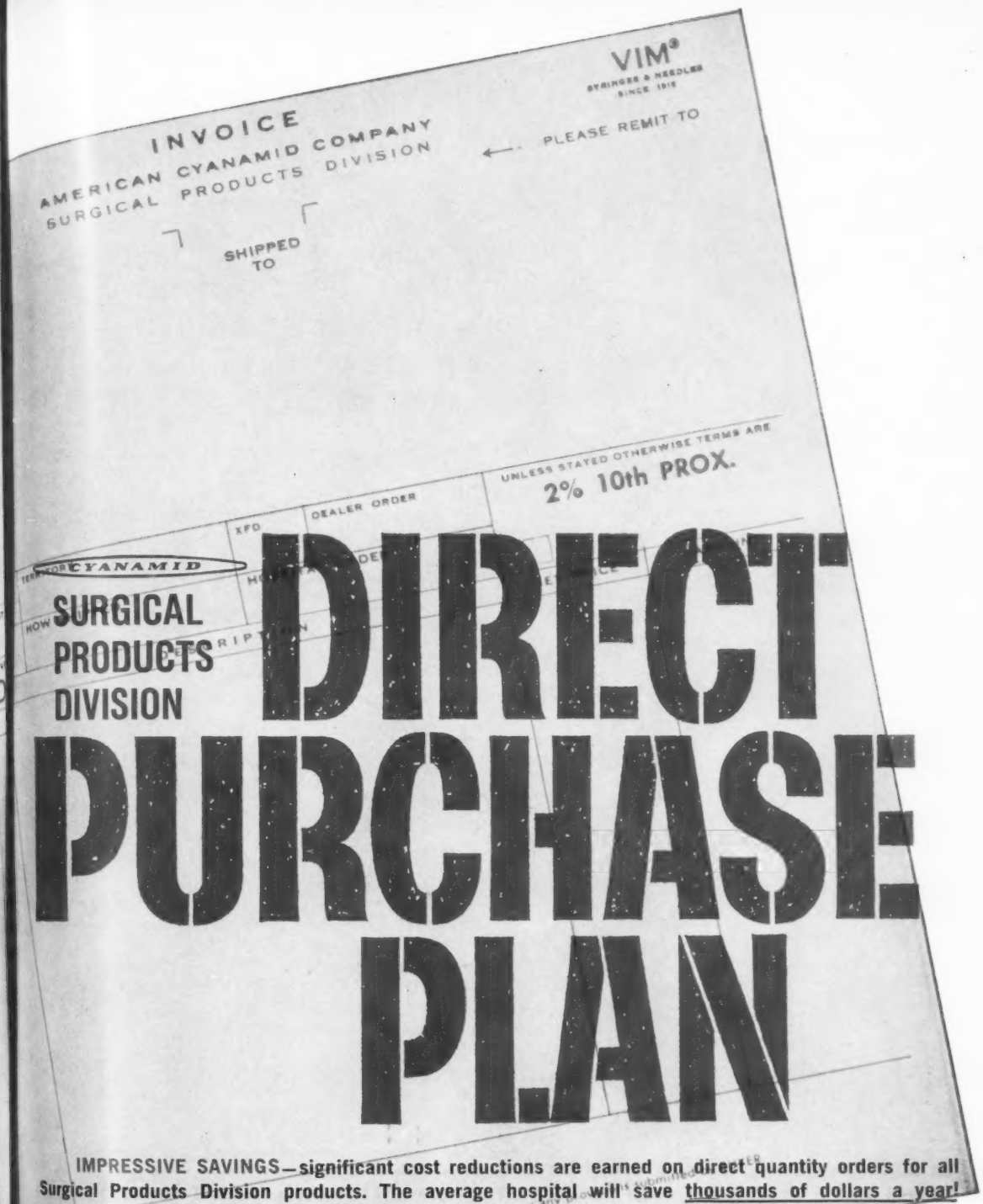
Your hospital can now purchase the finest and most advanced products in their field—D&G Brand Sutures, VIM® Brand Syringes and Needles, and a wide variety of surgical specialties—direct from the manufacturer.

The DIRECT-PURCHASE PLAN is a major step in our continuing program designed to bring you better products and more efficient service at the lowest possible cost. It offers your hospital important new benefits.



IMPRESSIVE SAVINGS—significant cost reductions are earned on direct quantity orders for all Surgical Products Division products. The average hospital will save thousands of dollars a year!

IMMEDIATE DELIVERY—no other manufacturer in our field can match the supply and service network of the Surgical Products Division. Highly trained staffs in 15 branch offices, coast-to-coast, speed your order from receipt to delivery... provide the fastest service you can get anywhere.

EFFICIENT, DEPENDABLE SERVICE—our extensive field staff and branch office personnel are constantly at your disposal... ready to work closely with Purchasing Departments and other key personnel to provide quality products and better service at lower cost.

Get full details on the new money-saving DIRECT-PURCHASE PLAN today! Contact your Surgical Products Division Representative or write for descriptive brochure C-1.

In Athens, too,

Pentothal is a favorite...

Pentothal is a name known wherever modern medicine is practiced. Time and time again throughout the years, it has proved itself to be a favored intravenous anesthetic in countless surgical procedures. Pentothal's versatility is documented by 24 years of use and over 2800 published world reports . . . a record of sureness and safety unsurpassed by any other intravenous anesthetic. Abbott

Pentothal® sodium

(Thiopental Sodium for Injection, Abbott)

Unmistakably the world's most widely used and studied intravenous anesthetic

Athens, Greece by Frederick Franck. A reprint of this painting on heavy stock suitable for framing, may be obtained by writing for "ATHENS" to: Professional Services, Abbott Laboratories, North Chicago, Illinois.

ATHENS, GREECE, BY FREDE

TOPICS

ATHEN

ATHENS, GREECE, BY FREDERICK FRANCK

Reliability in Action

Does your hospital still make many of its own parenteral solutions?

Then consider the advantages of now having them made by Abbott . . . by trained workers devoting *full* time to this one duty . . . using only the finest equipment . . . under continuous supervision by experienced career chemists . . .

. . . with control standards a model of scrupulous detail . . . with every bottle, vial, and ampoule individually inspected . . . samples and records of every lot preserved . . . and backed by Abbott's unique facilities and manpower in pharmaceutical manufacturing and the sciences.

Why accept the problems of parenteral manufacture? Turn your work over to specialists. Talk to your Abbott man.

Abbott Parenterals

SOLUTIONS AND EQUIPMENT

THE NORTH STAR, symbol of reliability in action, has guided the wanderer since recorded time. This Albert John Pucci painting is available on heavy 14½ x 19 paper without advertising, for framing. Write for "North Star" to Professional Services, Abbott Laboratories, North Chicago, Ill

prescription pad

For Rheumatoid Arthritis

Plaquenil, brand of hydroxychloroquine, a derivative of chloroquine, is now recommended by Winthrop Laboratories for treatment of rheumatoid arthritis.

Pharmacologically, Plaquenil has approximately one-fifth the acute toxicity of chloroquine. Clinically, side-effects are reported to be few and transitory in nature.

Plaquenil is supplied in 200-mg. tablets in bottles of 100.

Vitamin-Mineral Compound

In Ol-Vitum-M, Ives-Cameron Co. has added nine minerals to the multiple-vitamin preparation, Ol-Vitum.

The compound is designed for dietary supplementation in chronic or prolonged illness and malnutrition, as well as for patients on restricted diets.

Ol-Vitum-M is supplied in capsules, in bottles of 100.

For Psychotic Symptoms

Vesprin, a new phenothiazine derivative, is for control of psychotic manifestations and the alcohol withdrawal syndrome and for use as an antiemetic and antinauseant.

The drug is supplied by E. R. Squibb & Sons in tablets of 10, 25, and 50 mg. in bottles of 50 and 500, and in parenteral solution in 1-cc. ampuls containing 20 mg. per cc.

Respiratory Therapy

Rynatan, in tablet and suspension forms, has been released by Irwin, Neisler & Co. for sustained relief of upper respiratory congestion.

The compound employs an oral repository technic called Durabond to obtain prolonged effect.

Each Rynatan tabule contains phenylephrine tannate, 25 mg.; prophenpyridamine tannate, 37.5 mg.; pyrilamine tannate, 37.5 mg. Each 5-cc. teaspoonful of the suspension contains 5 mg. phenylephrine tannate, 12.5 mg. prophenpyridamine tannate, and 12.5 mg. pyrilamine tannate.

Preoperative Preparation

Mycifradin N tablets, introduced by the Upjohn Co., are primarily indicated for bowel preparation prior to surgery of the lower intestinal tract.

Each tablet contains 0.5 Gm. neomycin sulfate, wide-range antibiotic, and 125,000 units nystatin, antifungal agent.

Tablets are supplied in bottles of 20, 100, and 500.

Sustained Antacid Action

BEpHAN Spacetabs, introduced by Sandoz Pharmaceuticals, provide sustained antacid-anticholinergic action. They are said to avoid side-effects of constipation, alkalosis, and acid rebound.

Each Spacetab contains 0.5 mg. Bellafoline, 450 mg. aluminum hydroxide-glycine, and 60 mg. magnesium oxide.

BEpHAN Spacetabs are available in bottles of 100 tablets.

The NEW DUAL PURPOSE
VASELINE
PETROLATUM GAUZE U. S. P.
STERILE
3 x 3 PAD, opens to 3 x 9 INCHES
TEAR HERE
3" x 9" STRIP
Shorter length ends waste on small area wounds. New Z-fold insures perfect graft takes. Guaranteed sterile at time of use.
6th SIZE of VASELINE® PETROLATUM GAUZE
3" x 3" PAD
Three-ply, fine-mesh gauze, lightly impregnated — for use in physician's office, industrial medical department, first aid.
Now supplied in: 1/2"x 72" 3"x 18" 1"x 36" 3"x 36" 3"x 3"/ 3"x 9" 6"x 36"
Sole Maker:
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VASELINE is a registered trademark of Chesebrough-Pond's Inc.

BUYER'S GUIDE

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 144.

Evelyn Schwanke

Buyer's Guide Editor

100. Nursery camera

Nursery camera is designed to meet specifications for completely self-contained, electrical unit for use in hospitals. Within minutes after birth, babies in bassinets are placed under camera on center tray. Prefocused lens, together with scientifically adjusted, synchronous electric flash, takes perfectly exposed portrait. Beattie-Coleman, Inc.

101. Soap dispenser

Ped-O-Flo is foot-operated, liquid soap dispenser, designed for use in hospitals and doctors' offices. Made of plastic and stainless steel, dispenser is easy to install, economical in price. Meets most rigid requirements for surgical asepsis. Even flow of soap is assured at each depression of foot pump. Unconditionally guaranteed for one year. Liquid surgical soap refills available in glass containers. Peck's Products Co.

102. Surgical silk

Deknatel surgical silk is now available in new Plastic Pak, hermetically sealed and guaranteed against leakage. No change in sterility technic necessary. Surgical nurse merely cuts straight across transparent envelope, ejects reel, and frees suture from reel, with one hand. When end of suture is held, reel unwinds by its own weight. J. A. Deknatel & Son, Inc.

103. Linen truck

Heavy-duty basket truck for bulk handling of soiled or clean linens is now on market. Made of rugged, all-steel construction, has furniture-type finish for permanent good looks. Fully ventilated, truck is easy to keep sanitary. Plastic liner may be added for use in laundry. Trucks made in 8-, 14-, and 20-bushel sizes which nest when empty, saving floor space. Key-Tag Checking System Co.

104. Disposable canister

Canister Pak, disposable container for Sodasorb, has been introduced. Holds 1,640 cc. of Sodasorb, carbon dioxide absorbent for anesthetic and basal metabolism apparatus. A flexible Kraft paper container, lined with polyethylene and aluminum foil, canister facilitates pouring and storage. Sodasorb will continue to be sold in one and five gallon cans, also. Dewey and Almy Chemical Co.

105. Flame-retardant underpad

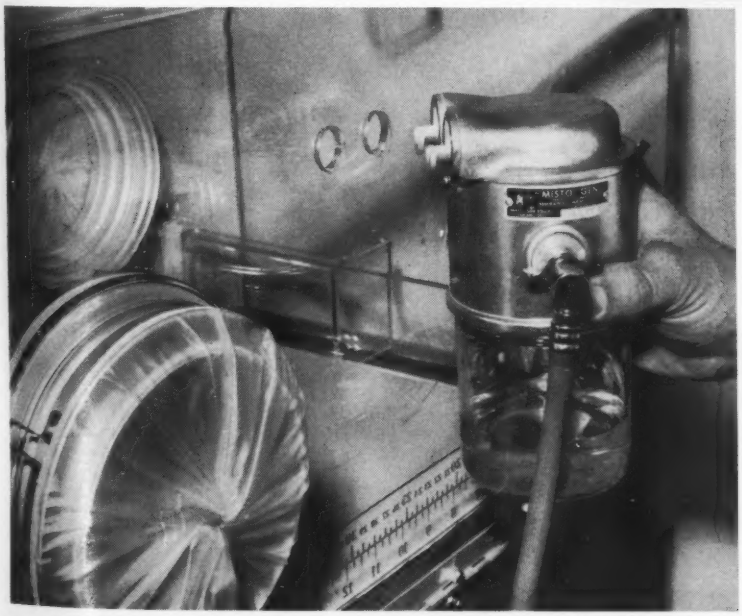
New flame-retardant underpad is Surgine Linen Saver. Measuring 17½" x 24", underpad meets Flammable Fabrics Act requirements for wearing apparel, is soft, highly absorbent, and completely non-irritating. Low in cost. Johnson & Johnson.

106. Colostomy bag

Coloplast is disposable plastic ileostomy and colostomy bag, easy to use, light in weight. Dispenses with belts and frames, is hygienic. No added weight or pressure to induce hernia. Solves problem of collection of urine from infants. Collection is made over a period of time, emptying may be carried out by means of a needle puncture, after which hole is sealed with adhesive tape provided with bag. Bittner Corp.

107. Orthopedic padding

Flex-O-Cel polyurethane foam is inert, synthetic material, for orthopedic padding, insulation. Odorless, non-toxic, non-allergenic, and x-ray permeable, it is unaffected by bacteria and all liquids except strong alkalis and acids. Perpetually elastic and self-ventilating. Medical Fabrics Co., Inc.

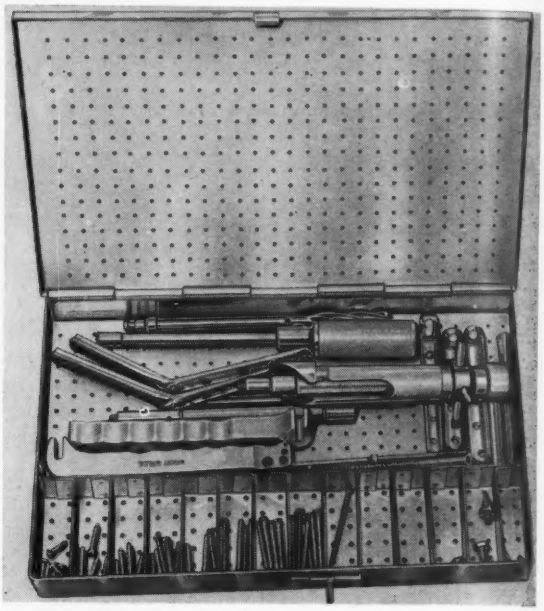


108. Incubator nebulizer

Mist O_2 Gen nebulizer fits all incubators, answers problem of standardization in nursery. Designed to attach directly to Isolette incubators, has universal adapter plate for Armstrong and other model incubators. Simple operation and maintenance. Incubator atmosphere is circulated and recirculated through twin ports. Oxygen may be diluted to 46% when desired. Large capacity model produces visible fog of therapeutically-effective size particles. Nebulizer attaches by positive holding metal lips to either plastic or metal plate import holes. Mist O_2 Gen Equipment Co.

109. Blood bank

New blood bank has wider-view, full length glass door for quick and easy inventory of contents. Adjustable revolving shelves allow removal of one bottle without disturbing other contents. Special mechanism provides uniform temperature throughout refrigerator. Dual safety controls and safety signal are standard equipment. Special 7-day recording blood bank thermometer is optional. Two model sizes for large and small hospitals. Jewett Refrigerator Co., Inc.



110. Hip tray

Dr. Basom hip tray is 14" long, 9½" wide, 1¾" deep. Made of 16-gauge stainless steel, has permanent, piano-hinged top. Fourteen smaller compartments hold screws, bolts, similar items; large compartment holds nails, instruments, threaded wires, Steinman pins. Wright Manufacturing Co.

111. Disposable cloth

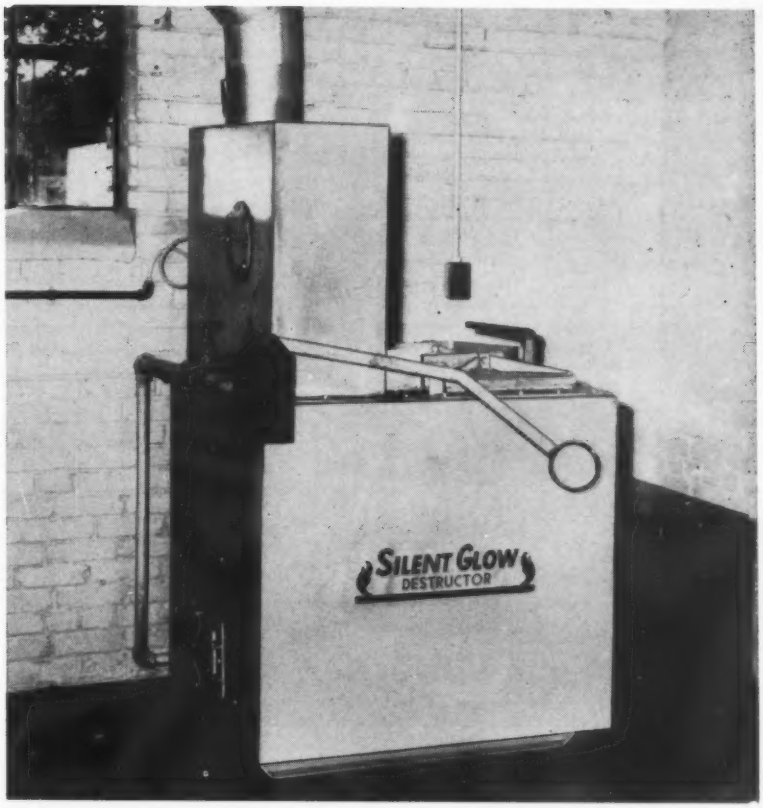
New, low-cost, disposable washcloth has been marketed for use in hospitals. Of fabric-like, pressed cotton, cloths are convenient 12" x 12¼" size. Busse Hospital Products.

112. X-ray salvage

New, nation-wide service now enables hospitals to convert old x-ray files into income. Silver from used or outdated x-ray films is salvaged and sold, freeing storage space and earning a profit. Film may be processed on "refining lot" basis, or company will buy film outright. Central receiving points have been set up to handle film quickly and conveniently from any locality. Handy & Harman.

113. Crematory destructor

Medical crematory destructor guarantees complete destruction of diseased organic matter and other medical waste with odorless, smokeless, fly-ash-free operation. Unit meets demands of federal agency pathological tests. Casings constructed of heavy, electrically-welded steel for ruggedness and durability, preventing warping. Interior made of 100% heavy insulating refractory construction. Coated finish of casing protects against corrosion. Unit mounted on heavy steel skids. Silent Glow Oil Burner Corp.

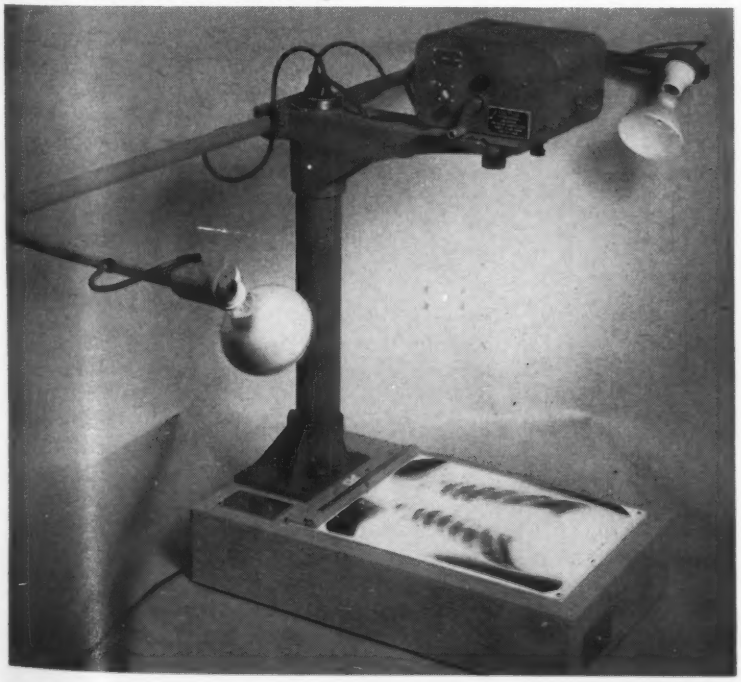


114. Hospital pen

Quick-drying, smudge-proof Ink-Pen-Cil solves writing problems peculiar to nursing and hospital charting. Ink available in red and blue, for a.m. and p.m. chart work, as well as green, black, brown, and turquoise. Pen body of tough, injection-molded plastic, matching ink color for easy identification. Choice of standard, fine, or extra fine point. Fisher Pen Co.

115. Microfilm camera

New Atlantic x-ray microfilm camera combines simplicity of operation with precision microphotography. Upright illuminator base positioned for proper reading and filming of x-rays. Two lights illuminate material to be microfilmed; three-position switch on base controls lighting. Foot switch provides automatic camera action, leaving hands free for handling material. Atlantic Microfilm Corp.



116. Stoppers

Tapered cups of polyethylene make excellent stoppers that are flexible, inert, easily cleaned. Cups are accurately molded with open tops, closed bottoms, uniformly tapered sides. Useful wherever stoppers are needed, or for dust covers or weighing dishes. Wide range of sizes available, from 17 mm. to 44 mm. Central Scientific Co.

117. Surgical shield

Improved surgical shield has sliding waist adjustments, enabling perfect fit for every patient. Hook fasteners make shield easy to adjust, even on unconscious patients. Shield designed to protect clothing and bedding from draining surgical wounds and from staining medication. Fuller Pharmaceutical Co.

118. Pipet

Ostwald-Van Slyke pipet, without stopcock, delivers blood samples into extraction chamber of Van Slyke manometric and volumetric blood gas apparatus. Rubber tips assure air-tight seal during delivery. Fisher Scientific Co.

119. Folding table

Folding table makes multi-purpose use of valuable hospital floor space. Patients may use it for eating, writing, reading, playing cards, other convalescent activities. Also provides extra table surface for patients' flowers and gifts. Easy to fold or open, stands firmly, can be stored in small space. Table measures 14¾" x 27½", stands 26¾" high. Top is patterned Micarta. Howe Folding Furniture, Inc.

120. Wall covering

Koroseal vinyl wall covering, in "Linen Weave" pattern, duplicates appearance of fine linen. Colors are styled expressly for walls, in pastel and medium shades required for institutional use. Available in 20 colors. Material is flame-retardant and fire-resistant. B. F. Goodrich Co.

121. Vacuum regulator

Fingertip adjustment from 120 mm. of mercury vacuum pressure to 90 mm. is feature of new Intermittent Vacuum Regulator. Unit is designed for post-operative gastrointestinal care in which tubes such as Levine or Miller-Abbot types are used, or when intermittent drainage is required. National Cylinder Gas Division, Chemetron Corp.

122. Massaging agent

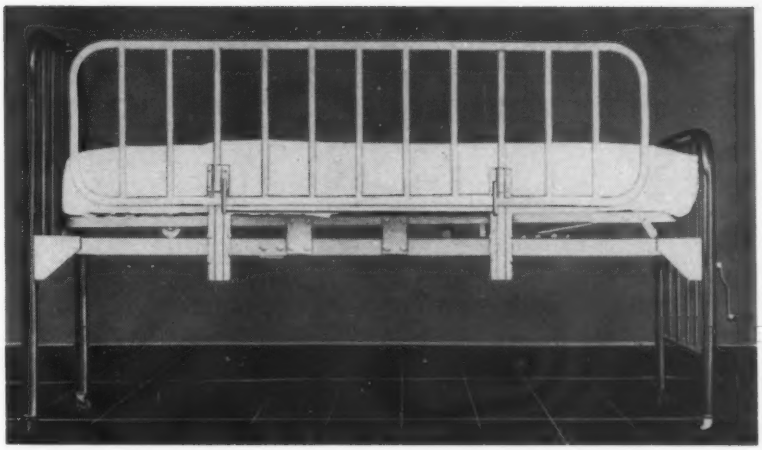
Schuco Alco-Rub is economical, convenient massaging agent for patients. Contains silicone which acts against contact dermatitis, frequent problem with confined patients. Gives cooling sensation. Comes in 16 oz. container, which distributes fine particles evenly. Medical Products Division, Schueler & Co.

123. Automatic door operator

Mechanism of automatic door operator is contained in single, ingenious, compact unit, not much larger than ordinary door check. Simple installation consists of attaching door operator to door, making a few simple electrical connections. Is as readily applied to existing doors as to new construction. Operator is supplied with either mat switches or photo-electric controls. Operation has been subjected to laboratory tests under all conditions. Compact, streamlined design presents handsome appearance on any door. No elements need be installed in floor. Adaptable for all types of entrances and exits, as well as service doors. Electronics Corporation of America.

124. Safety sides

Lightweight aluminum safety sides for hospital beds are made of high tensile aircraft alloys, are sturdily constructed. Two-position bracket fits Trendelenburg or standard gatch springs. Other features are permanently lubricated nylon bearings, positive safety lock, adjustable brackets which fit most types of beds, no loose parts or elements to cause maintenance problems. Half sides, of same construction, are available, having a one-position bracket which attaches to head section of gatch spring. Beam Metal Specialties.



125. Disposable syringe

Wide range of sizes has been added to line of disposable syringes, including 1 cc., 2 cc., 5 cc., 10 cc., 20 cc., and 40-80 units, and selection of 17 sizes of needles. Admiral Corp.

127. Intramedic tubing

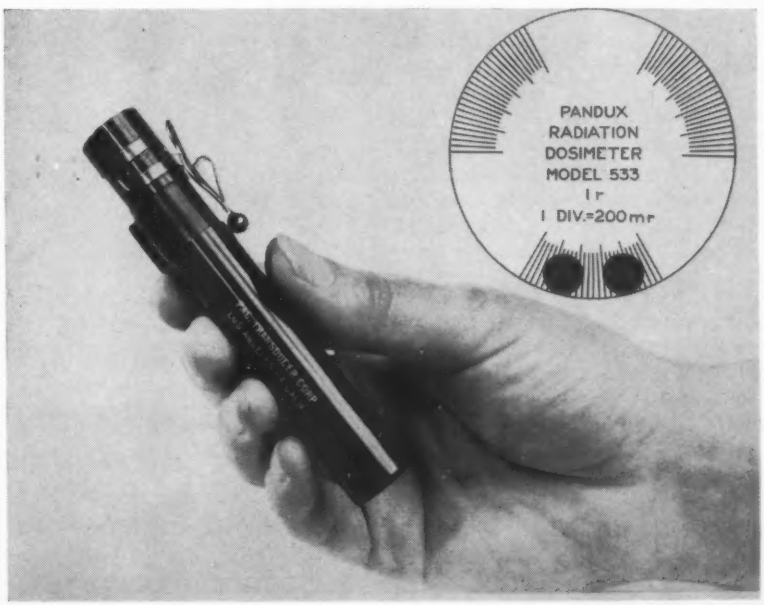
Intramedic polyethylene tubing now available, sterile and ready for use, in 7 most needed sizes. All sold in 12″ and 36″ lengths. Three new sizes, not previously available in sterile form, are PE-160, 205, and 240. Eighteen, 16, and 15-gauge needles, respectively, will fit into lumens of these tubing sizes. All tubing is electron-sterilized after packaging, and ready for use from the package without further treatment. Double-packed tubing is placed in inner glassine envelope, then within heat-sealed outer polyethylene envelope. Complete sterilization of package and its contents is achieved instantly. Clay-Adams, Inc.

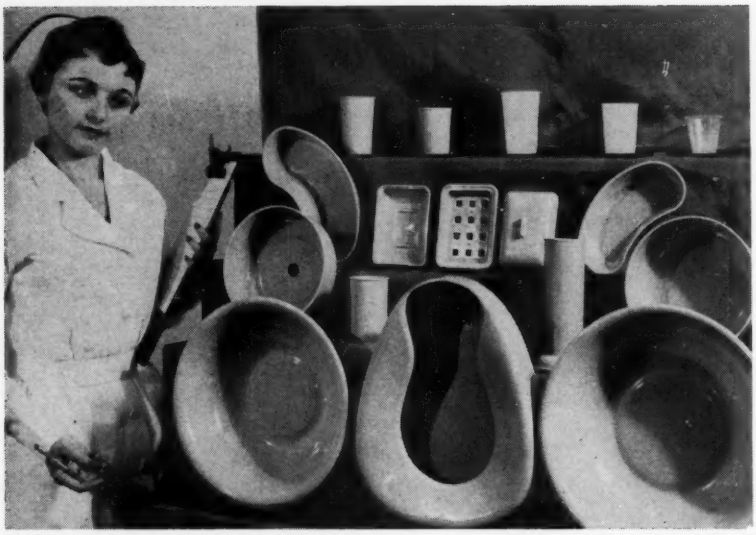
128. Traction standard

Precision-constructed, adjustable traction standard is designed for use with the Camp head halter device. Can be used with any style chair, allowing patient to take prescribed traction treatment while reading or otherwise relaxing. Made with galvanized metal tubing and cadmium-plated wire parts, apparatus adjusts easily between heights of 34″ to 78″. Self-locking, frictionless pulleys are of nylon. S. H. Camp & Co.

126. Radiation detector

New low-cost, pen-type personal dosimeter uses principle of "charged spheres." Radioactive exposure is read by checking angular distance between charged spheres. Accurate readings are obtained by means of simple optical system and reticle. Instrument does not require special charging equipment, is hermetically sealed against moisture, has an indefinite life. Accumulated exposure over long period of time may be read, as leakage is less than 1/100 of 1% per day. Accuracy is plus or minus 20% under all conditions. User may recharge it by simple method of agitation. Pacific Transducer Corp.





132. Plastic utensils

Complete line of fully autoclavable hospital utensils in new plastic, called Pro-fax, now available. Provide added comfort and ease of handling, less maintenance. Highly resistant to stains, chemicals, and saline solutions, lightweight and virtually unbreakable. Colors are aqua or white. Can withstand temperatures up to 300° F. without distortion, discoloration. Line includes bedpans, emesis and wash basins, needle trays, toast covers, soap dishes, drainers, and covers. Increased service life contributes to long-range economy. Low thermal conductivity of bedpans eliminates pre-warming, and bed patients appreciate flexibility of plastic. Hercules Powder Co.

129. Emergency lighting

In the event of power failure during surgery, illuminating power is instantly switched to "battery" by the PowerPak 582. New unit is equipped with a dual voltage supply which permits carrying a mixed 12- and/or 18-volt load in any combination that does not exceed a total load of 250 watts. This dual voltage feature makes it possible to have illumination both from major operating lights and from a general room illumination light in the event of an emergency blackout. Uninterrupted illumination is insured by an 18-volt portable light or ceiling light permanently connected to the PowerPak. The terminal block that energizes this emergency light functions only during power failure, and current is drawn directly from the batteries. Wilmot Castle Co.

130. Glove package

Rapak glove package holds one pair of Wilson surgeons' gloves in double envelope of two-way stretch Kraft crepe paper, delivers them ready for sterilizer. Gloves are dusted with Bio-sorb, have gauze pads in each wrist, come with a disposable, soft paper drape, and an extra packet of Bio-sorb. Envelope is sealed with color indicator tape on which glove size is stamped. Wilson Rubber Co., division of Becton, Dickinson & Co.

131. Leg exerciser

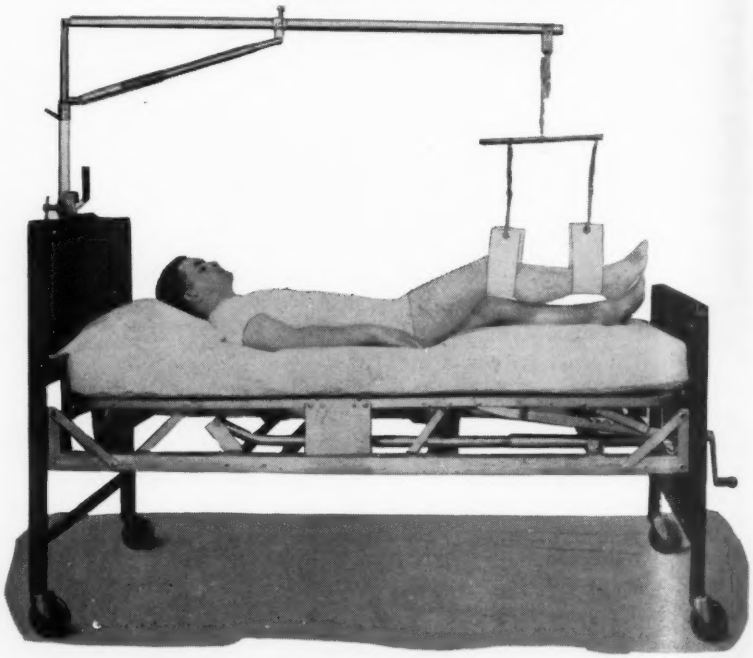
New leg exerciser can be attached to any bed of standard dimensions. Made of Octagon aluminum tubing, connected to slings and rocker arm by chains. Arm and slings adjustable for proper lift to balance leg; adjustable spring in upper unit provides lift to suspend leg. Zimmer Mfg. Co.

133. Blood donor couch

Unique 3-position Sera-Sofa donor couch affords greater comfort and efficiency, is said to reduce psychological reaction by 60%. Contour shape puts donor at ease, assures relaxed frame of mind. Technicians appreciate improved donor position, convenient working height, simple adjustment. Couch has foam rubber mattress. Both head and foot may be elevated. Pastel-colored Boltaflex covering, contour shape avoid institutional appearance. The MacBick Co.

134. Needle retriever

Powerful permanent magnet in swiveling head of Sierra magnetic needle retriever attracts small metal particles, eliminating stooping or mopping to pick up dropped surgical needles or small instruments. R. A. Hawks Division, Sierra Engineering Co.



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3M COMPANY

NEW LITERATURE

140. Fluid therapy rates

A convenient pocket reference chart of parenteral solution administration rates has been developed. Chart gives number of drops per minute necessary to administer routine amounts of solution within prescribed times.

Also included are maximum utilization rates for dextrose, invert sugar, and absolute alcohol, together with basic precautions to be observed in fluid therapy. Amsco Hospital Liquids, Inc., subsidiary of American Sterilizer Co.

141. Photometric technic

Simple flame photometric technic for determining minute quantities of magnesium in body fluids is described in new Beckman application data sheet. Material outlines new magnesium analysis technic with Beckman DU Flame Spectrophotometer, which permits determination of the element in concentrations of 1 to 2 mEq./liter. Beckman Scientific Instruments Division.

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FOR ACCURATE INFANT
URINE COLLECTION!
Sterilon
PUC-10 PAT. PEND.
Pediatric Urine Collector
for Male and Female Infants
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Pressure sensitive adhesive at opening fits infants of both sexes. Patented deflector arc permits easy use by female. Cannot spill or leak. May be worn under diaper.
After use, bag can be folded and self-sealed for transporting urine to lab or pediatrician's office.
"Quality is our Cornerstone"

142. Surgical instruments

New, illustrated 250-page catalog is available for line of stainless steel surgical instruments. Includes instruments for obstetrical, gynecological, rectal, eye, ear, nose and throat, neurological, gastric, intestinal, and general surgery. Dittmar-Penn Corp.

143. Lab glassware

A 350-page, color-coded catalog for Pyrex brand laboratory glassware has been issued. Contains complete listing of borosilicate glass chemical ware and apparatus. Included are 474 new items. Lists both standard and custom-made equipment. Corning Glass Works.

144. Food service

Food Service in the Modern Hospital is new brochure explaining concept of mechanized hospital food service. Illustrated with many diagrams, photographs, and schedules, it is of interest to hospital administrators, food service department heads, consultants. Samuel Olson Mfg. Co.

145. Molded handwear

Gloves, made of five types of molded rubber and synthetic materials, in various weights, sizes, and types are described in new 8-page bulletin. Line of finger cots is also outlined, and selection guide for items is featured. Mine Safety Appliance Co.

146. Oxygen therapy

New catalog covers Hudson line of oxygen therapy equipment. Included are Hi Humidity croup tent and new plastic oxygen mask. Hudson Oxygen Therapy Sales Co.

147. Metal shelving

Catalog suggests correct shelving for storage of various kinds of materials, loose and packed parts, books, and record files. Storage cabinets are also described. Deluxe Metal Furniture Co.

148. Parking lot plans

Parking Techniques is guide, for institutional use, for better parking lot planning. Several diagrams show suggested space allocations, with minimum and optimum dimensions for each arrangement. Harris-Barrier, Inc.

TOPICS' Camera Focuses

On Technical Exhibits

Items of interest to hospital personnel in all departments have been displayed in recent weeks in the technical exhibits which have formed an important part of hospital association meetings throughout the country.

On this and the following four pages are some of the products shown at the Tri-State Hospital Assembly, held April 28-30 in Chicago. Page 96 features items exhibited at the Association of Western Hospitals convention, April 21-24, in San Francisco, and the American College of Obstetricians and Gynecologists meeting, April 21-23, in Los Angeles.

After you've browsed through the displays along with TOPICS' camera, check the return post card opposite page 144 to get further information on products you're especially interested in.

Below, left: Erna E. Spader, surgical secretary, VA West Side Hospital, Chicago, relaxes as she tests features of Doyle Products Company's "Selectric" bed, described by Robert H. Lee, Doyle. Push buttons raise or lower foot and head of bed instantly. Beneficial for heart and respiratory ailments, asthma. C-160

Below, center: Winifred Jones, director of George V Memorial Hospital, Liguanea, Jamaica, who is traveling in this country on a World Health Organization fellowship, visited the Tri-State Assembly. Tom Williams, Jr., Debs Hospital Supplies, Inc., shows her PKS, Debs' patient card system which enables the nurse to communicate instructions for patient care. C-161

Below, right: Another visitor to this country, F. Corner, Durham, England, manufacturer of hospital equipment, stops to look at items displayed by Rehabilitation Products, division of American Hospital Supply Corp. LeRoy Meyer, registered physical therapist with American Hospital Supply, shows him the "Scottie" wheel chair, low-priced, folding wheel chair incorporating many features of more expensive models. C-162

Above, left: "Time tape" display of Professional Tape Co., Inc., catches the interest of Marie C. Shepard (l.), head nurse, surgical floor, and Leone Morrisey, supervisor, central service, both of St. Joseph's Hospital, Aurora, Ill. Michael Greco shows them the self-sticking, vinyl-coated labels, which provide safe, fast, accurate labeling for every department in the hospital. C-163

Above, right: A visitor in the American Sterilizer Co. display room was Carl G. Murphy (l.), administrator, Sarah D. Culbertson Memorial Hospital, Rushville, Ill. Bengt Johanson, American Sterilizer, explains features of the Cry-O-Therm "cold" sterilizer, which utilizes non-inflammable gas. Effective for use in urology, EENT, surgery, central service, contagious units. C-164

Right: Two Hinsdale (Ill.) Sanitarium and Hospital head nurses visited the Steri-Syringe Co. booth. Marion D. Brodie (l.), nursery, and Juanita Glaylock, OB, listen as Jerome Sperling lists advantages of Steri-Syringe disposable, plastic hypodermic syringes including reduction of cost, labor, danger of contamination, and accidents due to breakage. C-165

Left: "Castle Unit," new ultrasonic cleaner, was exhibited by Wilmot Castle Co. William Frey sets timer dial to begin automatic "silent sound" cleaning cycle as C. Joyce Coad, chief pharmacist, Proctor Community Hospital, Peoria, Ill., watches. Basket holds 75 to 100 instruments, and will accommodate even large sizes. Unit operates on 5- to 15-minute cycle. C-166

Below, left: Featured at the John W. Maselter Co. display was the Tractomatic portable intermittent traction machine being shown by John W. Maselter to Anne Burbach (l.), pediatric occupational therapist, and Martha Blake, student nurse, both of Michael Reese Hospital, Chicago. Motor-driven unit can be adapted to vertical cervical traction, horizontal cervical traction, or pelvic traction. C-167

Below, right: Dorothy Patterson, assistant nursing arts instructor, Silver Cross Hospital, Joliet, Ill., operates push-button control for electric hospital bed introduced by American Metal Products Co. at Tri-State. M. R. Steere shows her how side rails store under mattress panels, permitting full working clearance for nurse. Bed has eight motorizing actions, can be raised or lowered 15 inches. C-168

Above, right: Bennett Model PR-1A respiration unit attracts attention of Bert Hanson (second from left), administrator, Memorial Hospital for McHenry County, Woodstock, Ill., John Green, administrator, Guernsey Memorial Hospital, Cambridge, O., and William Lyon (r.), assistant administrator, Methodist Hospital, Gary, Ind. Gordon Eaverson (l.), Puritan Compressed Gas Corp., demonstrates combined intermittent positive pressure breathing therapy unit and hospital resuscitator. C-169

Above, left: St. Xavier College, Chicago, School of Nursing instructors, Helen Czarnecki (center) and Delores Mlatkowski, stop at Aeroplast display to inspect Vi-Drape, plastic surgical drape. Paul Creager, Aeroplast, explains how drape may be applied directly to operative area and incision made through the film. C-170

Left: Easy adjustment of DePuy arm traction frame is demonstrated by Paul Harris (l.), DePuy, as Anthony DeVries (center), engineer, and Robert Wiley, purchasing agent, both of Roseland Community Hospital, Chicago, watch. Designed primarily for the arm, frame may also be used at foot of bed for leg or foot traction. Framework is attached easily to bedsprings. C-171

Right: Portable emergency oxygen unit was featured at Oxygen Equipment & Service Co. booth. Albert E. McKee, technical representative, shows it to Mrs. Elmer Wood, president, Marion (Ind.) General Hospital Auxiliary. Weighing only 2½ lbs., unit can be hung on wheel chair, placed on stretcher, or used in any emergency situation. It supplies approximately 100 percent oxygen for 12 minutes, is self-contained, easy to operate. C-172

Below, right: Peggy Ryan, medical record librarian, learns how conventional telephone may be used to communicate with patients through new nurses' call system, as Betty Petzel, head OB nurse, waits her turn. Both are of St. Bernard's Hospital, Chicago. They stopped at the Royal Communications Systems booth, manned by Lee Barsi. System uses transistorized amplifier, can be installed by the hospital electrician. C-173

Below, left: Even bassinets now come in disposable form, LaVerne Sweeney (r.), Presco Co., tells Lois K. Grebner (center), head nurse, surgical floor, Deaconess Hospital, Freeport, Ill., and Mrs. A. A. Gummerson, staff nurse, Monmouth (Ill.) Hospital. Disposable bassinet is designed to help reduce cross-infection, solve problem of over-crowded nurseries. Made of rigid, water-resisting Flute-wood stock, bassinet comes in pink or blue, fits most bassinet stands. C-174

Above, left: William B. Hennessy (l.), pharmacist, and Francis P. Breen, assistant administrator, both of Saratoga General Hospital, Detroit, were interested in the new traction frame which Edward S. Edwards, Gilbert Hyde Chick Co., demonstrated. The model is Mari Foster. Frame is new accessory for Foster orthopedic and fracture table. C-175

Above, right: Henrietta Drager, administrator, Henrotin Hospital, Chicago, samples comfort of combination lounge and bed exhibited by L. B. Herbst Corp. Frank L. Fischer demonstrates positive locking mechanism of unit, which has ball bearing rear wheels, completely welded frame, storage compartment in sleeper. Lounge is adaptable to nurses' and students' dormitories, doctors' and interns' quarters. C-176

Right: Gordon Anderson shows Ruby Products Company's new plastic medicine cups, at the Will Ross, Inc., booth. Joan C. Spreer (l.), and Kathleen M. Sager, both instructors in nursing, Augustana Hospital, Chicago, examine disposable, transparent cups, marked with accurate graduations, capable of holding one fluid ounce each. C-177

Left: Accuracy of measurement obtainable with Stylex expendable hypodermic syringe is pointed out by Rod Meredith, Pharmaseal Laboratories, to Edna I. Marks (l.), and Melba J. Robson, both medical technologists, Argonne Cancer Research Hospital, University of Chicago. Barrel and plunger of syringe are preassembled, ready to use. Convenient dispensing carton contains 100 sterile, individually wrapped units. C-178

Below, left: James F. Mongiat (l.), supervisor, urology department, Hines (Ill. VA Hospital, is an interested visitor at the Baxter Laboratories booth, which highlighted the Travenol twin coil artificial kidney. Safety, simplicity, and economy are features of disposable kidney, which removes water as well as solutes, assures sterility, and eliminates risk of transmitting hepatitis through dialyzing unit. Jim Darst of Baxter is showing unit. C-179

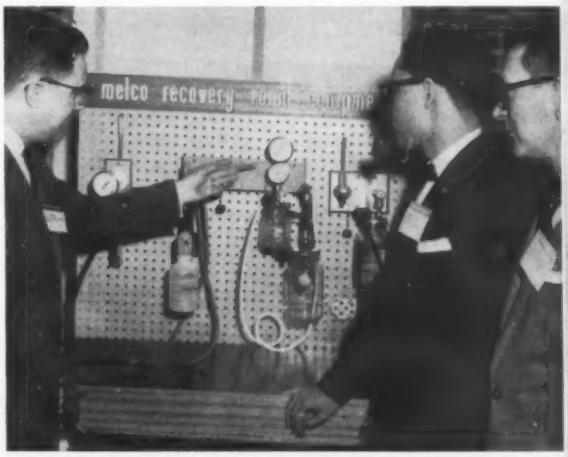
Below, right: Walter O. Kenzie, Ar-Kay Industries, Inc., operates Bunn glove tester, manufactured by John Bunn Corp., as Grace G. Peterson, instructor, department of nursing, DePaul University, Chicago, watches. Tester provides fast, positive inspection of surgical gloves, facilitates spotting holes. C-180

Above, right: Chicago anesthetists, Rose Marie Bly (l.), Illinois Central Hospital, and M. Elizabeth Kuehl, Ravenswood Hospital, included the Davol Rubber Co. booth among their stops. Harald N. Chester shows them Davol's new Feed-Rite Supreme unbreakable plastic nurser which can be sterilized with no loss of shape or strength. Nipple cover permits true terminal sterilization. C-181

Above, left: Interested group inspecting Bird respirator, at Randolph Surgical Supply Co. booth, includes (l. to r.): Larry Fruik, supervisor, inhalation therapy department, Edgewater Hospital, Chicago; Donald Livingston, supervisor, inhalation therapy department, South Chicago Community Hospital; Jack Cannon, assistant supervisor, inhalation therapy department, Edgewater Hospital; and Don Randolph, Randolph Supply. Residual breather is light-weight, simple in design. C-182

Left: Complete head-end control of Surg-a-matic operating table is demonstrated by Robert B. Tucker, Shampaine Co., as Suzanne Brickson, O.R. nurse, and John R. Kohl, director of nursing, both of Stoughton (Wis.) Hospital, look on. Anesthetist remains seated at all times; convenient push button controls select wide range of positions. C-183

Right: Therapeutic advantages of Melco recovery room equipment are explained by Guy Doyal (l.), American Hospital Supply Corp., to Thomas B. Reed (center), laboratory technician, and Leo T. Pope, x-ray technician, both of Morris (Ill.) Hospital. Melco equipment is capable of delivering all types of suction, aspiration, thoracic, or Wangensteen type. It is controlled both in depth and in volume, directly from a wall outlet. C-184



Below, right: Clarissa Esser, executive housekeeper, Mount Sinai Hospital, Milwaukee, has a question about the dual control Hilow bed displayed by Hill-Rom Co., Inc. Ed Hannon explains that bed's push button controls are at patient's right, in convenient section of bedspring. One motor does entire work of operating all-electric bed, which is fully approved by UL as safe for use with oxygen. C-185

Below, left: Meter of Ohio Chemical Company's Conducheck is read by Jean Levin (center) and Joyce Rhoton, occupational therapists interning at Winfield (Ill.) Tuberculosis Service. Roger Crosby, Ohio Chemical, explains use of machine, designed to test conductive footwear each time wearer enters an area where anesthetic gases are used. Preserves surgical aseptic technic, since there are no buttons to push, no adjustments to make. C-186

Left: Electronic registry system for staff physicians is examined by Harold H. Hixson (l.), administrator, and Jerome M. Yalon (r.), associate administrator, University of California Hospitals, San Francisco, at Western meeting. Dick Toole, Toole Electronics, points out that boards are flush mounted and built in modular sections of 20 names each, for combination in any number. Units lock electronically. C-187

Center: Stainless steel instruments imported directly from West Germany were featured at the Erwin Neugebauer booth. Here Mr. Neugebauer shows Sister Mary Ralph, surgical supervisor, St. Mary's Hospital, San Francisco, a Kelly forceps and mosquito forceps. At right are Mrs. Eva Kelly, of the Neugebauer company, and Barbara A. Kroetz, student nurse, St. Mary's. C-188

Right: Faye Brown, medical record librarian, Loma Linda (Calif.) Sanitarium and Hospital, tries out pocket-size Microcard reader, which enables reading of Microtape record cards at desk, in laboratory, or at home. Dick Freeman and Ken Carleton, Bay Microfilm Service, explain use of device, which includes reading unit, small transformer-plug, connecting cord for use with 110-volt current, and protective plastic cover. One 3x5 Microcard can hold 40 pages of 8½" x 11" material in Microtape form, made from 16mm. or 35 mm. microfilm negative rolls. C-189

Below: At meeting of American College of Obstetricians and Gynecologists, Chicago Pharmacal Co. introduced "Prenaphos Protection Program." B. T. Reid (l.), general sales manager, Chicago Pharmacal, explains to Fred Mooney, Chicago, that plan insures pregnant patients against fetal mortality or involuntary abortion during last six months of pregnancy as long as patient is maintained on Prenaphos, new, complete dietary supplement. C-190

Below: Turgasept, an ionic deodorizer aerosol, was introduced by Doho Chemical at the AWH meeting. Here Hal Silberman (third from left), Doho, shows the product, which is described as "a new concept in malodor control," to (l. to r.) Angie Engstrom, R.N., supervisor of surgery, and Virginia M. Hourihan, R.N., superintendent of nurses, Ukiah (Calif.) General Hospital; Charles J. Smith, administrator, Malheur Memorial Hospital, Nyssa, Ore.; and Lois J. Naughten, administrator, Silverton (Ore.) Hospital. Product, designed for use in hospitals and nursing homes, is supplied in 16-oz. aerosol spray can, and is also available in 2-oz. concentrate to be mixed in one gallon of hot water. C-191

MINIMETER/*for accurate dosage*

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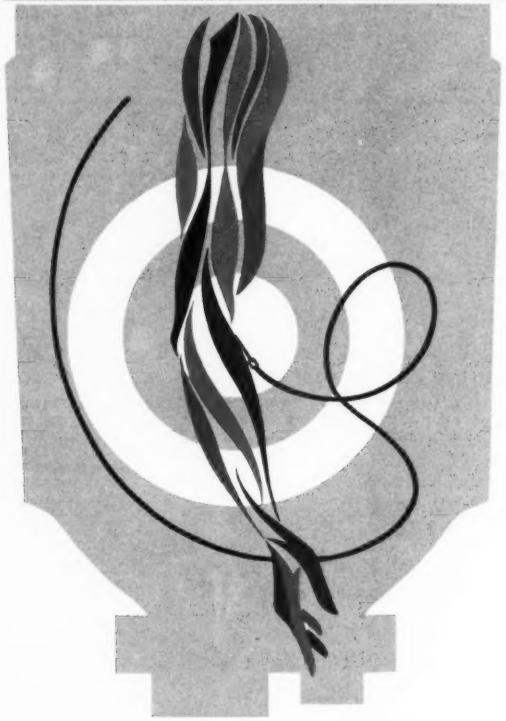

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ASMT to Hold 26th Convention in Milwaukee

The 26th annual convention of the American Society of Medical Technologists will be held in Milwaukee June 15-20.

Theme of the meeting is "Growth Through Co-operation."

A panel discussion on blood banking will be presented by Philip Levine, M.D., Ortho Research Foundation, Raritan, N. J.; Tibor J. Greenwalt, M.D., medical director, Milwaukee Blood Center, and associate clinical professor of medicine, Marquette University School of Medicine; and Ned G. Maxwell, M.D., associate medical director, Milwaukee Blood Center.

Armand J. Quick, M.D., professor of biochemistry and director, biochemistry department, Marquette University School of Medicine, will present a seminar on "Recent Advances in Blood Coagulation" on Monday afternoon, June 16.

A seminar on "Radioisotopes and the Diagnosis of Hematological Disease" will be given on Tuesday morning, June 17, by Anthony V. Pisciotta, M.D., associate professor of medicine, Marquette University School of Medicine, and director, Blood Research Laboratory.

That afternoon a seminar on histochemistry will be presented by William Norris, Ph.D., Argonne National Laboratory, Lemont, Ill., and Sylvia H. Bensley, M.D., associate professor of anatomy, University of Toronto.

Other speakers and their subjects include:

William D. Demeshek, M.D., professor of medicine, Tufts University School of Medicine, and director, Blood Research Laboratories, New England Center Hospital, Boston.—"Hematology."

Lucille K. Georg, Ph.D., mycology unit, Communicable Disease Center, Chamblee, Ga. — "New Methods in Medical Mycology."

Robert W. Boyle, M.D., associate professor of physical medicine and rehabilitation, Marquette University School of Medicine, and director, department of physical medicine and rehabilitation, Milwaukee County Hospital.—"Some Pertinent Remarks About Growing Older."

Leo G. Abood, Ph.D., associate professor and director, neurophysiology laboratories, department of psychiatry, University of Illinois College of Medicine.—"Chemical Indices in Mental Illness."

Robert D. Taylor, M.D., Marquette University School of Medicine.—"Renal Function Tests."

William D. Stovall, M.D., director, State Laboratory of Hygiene, Madison, Wis., and professor of hygiene, University of Wisconsin Medical School. — "Complement Fixation Tests in the Recognition of Histoplasmosis and Toxoplasmosis."

Gerald M. Needham, Ph.D., bacteriologist, Mayo Clinic, Rochester, Minn.—"The Role of the Laboratory in Antibiotic Therapy."

John M. Huston, M.D., assistant professor and director of the cardiopulmonary laboratory, department of medicine, Marquette University School of Medicine.—"What Cardiac Catheterization Is All About."

Stanley Weinreb, Ph.D., direc-

(Continued on next page)

Right: Members of the board of directors of the Illinois Medical Technologists Association met during the recent Tri-State Hospital Assembly in Chicago, to discuss association business. They are (standing, l. to r.): Grace Knox, mycologist, Billings Hospital, Chicago, president of the Chicago section, IMTA; Doris S. Whitney, Roselle, executive secretary, IMTA; Bernice Gantzert, Chicago, president; and Ellen Deffenbaugh, Glenview, chairman of the scholarship committee. Seated are (l. to r.): Emma Albert, department of public health, State of Illinois, Chicago, chairman of the education committee; Mary Turner, bacteriologist, University of Illinois Research and Education Hospitals, Chicago, editor of IMTA newsletter; Sister Serena Haas, chief technologist, St. Clement's Hospital, Red Bud, treasurer; and Verna Pittard, chief technologist, Passavant Memorial Hospital, Chicago, chairman of the recruitment committee.

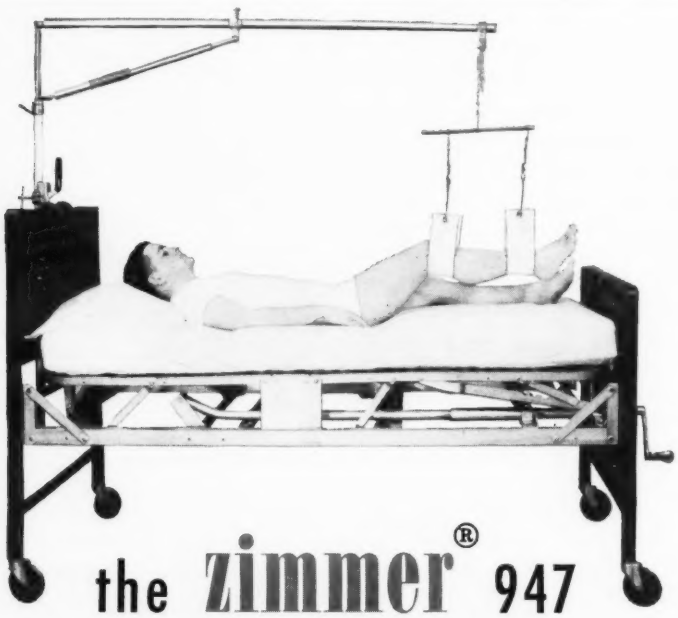
tor, Bob Quinn Memorial Electron Microscope Laboratory, Marquette University School of Medicine.—"The Electron Microscope."

John S. Hirschboeck, M.D., dean, Marquette University School of Medicine.—"The History of the Blood Sedimentation Rate."

E. G. Bertram, Ph.D., assistant professor of anatomy, Marquette University School of Medicine.—"Congenital Errors of Sex Developments."

President of the ASMT is Leanor D. Haley, Ph.D., M.T. (ASCP), assistant professor in medical microbiology, Yale University School of Medicine, and director, microbiological laboratories, Grace-New Haven Community Hospital, New Haven, Conn.

Dr. Haley will be succeeded at the meeting by Elizabeth O'Connor, M.T. (ASCP), Evanston, Ill.



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By slinging the leg (or arm) in free suspension, the Zimmer Hip Exerciser helps the patient keep his joints and muscles toned up for faster recovery after tedious confinement.

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U.S. Medical Schools Need $275 Million for Building

U.S. medical schools will need at least $275 million within the next few years for construction of new teaching facilities and rehabilitation of outmoded ones, according to Lowell T. Coggeshall, M.D., president, Association of American Medical Colleges.

Commenting on the results of a survey just completed by the association on the needs of the eighty-five medical teaching centers in the U.S., Dr. Coggeshall said that approximately $25 million is needed for rehabilitation, and $250 million for new construction if schools are to maintain current standards of teaching, research, and patient care.

The survey included teaching facilities only, and did not cover needed research and hospital construction. In the survey, the schools stated that if their construction needs could be satisfied, they could increase their current output of physicians from approximately 7,000 a year to 8,000.

VA Forms Division for Research in Aging

The Veterans Administration has formed a new division of its department of Medicine and Surgery to conduct research on the aging process and to co-ordinate the approximately 2,000 studies of disorders associated with aging now under way in VA hospitals.

Charles C. Chapple, M.D., former chief, VA clinical studies division, will head the new unit. The program will be developed under guidance of an advisory committee of five university consultants. Chairman is Ralph W. Gerard, M.D., professor of neurophysiology, Mental Health Research Institute, University of Michigan.

The VA has also announced a long-term survey to be carried out in all 173 VA hospitals to provide information on treatment of patients with cancer.

Data collected will include material on diagnosis and treatment, clinical information for research and epidemiological studies, and statistics for planning purposes.

Virus, Staphylococcal Infections Discussed by Pediatricians

Pediatrics

Report on Spring Session, American Academy of Pediatrics, New York City, April 21-23

Mass Immunization Proves Effective For Controlling Virus Epidemic

Virus Disease Treatment Must Aim to Relieve Symptoms

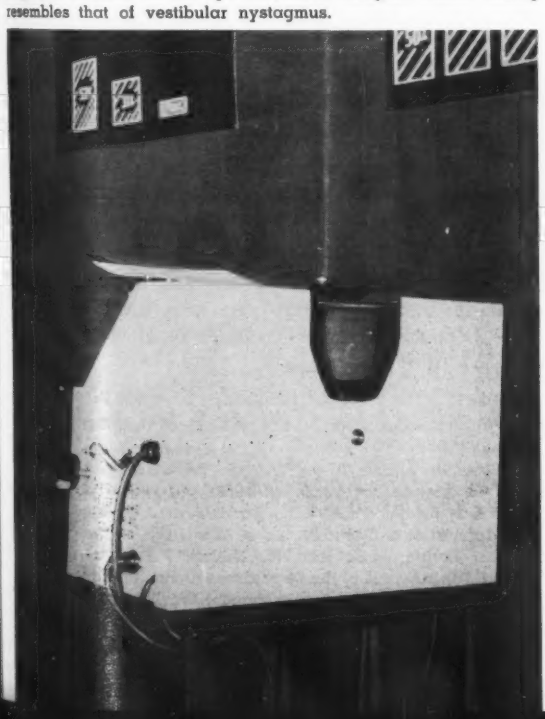
Mass immunization has proved to be an effective measure for controlling the spread of virus infections.

In a study conducted by the commission on influenza of the Armed Forces Epidemiology Board at Fort Dix, N. J., 85 percent of a group of recruits inoculated against influenza remained unaffected by the disease.

However, most virus diseases have low morbidity rates. Only when the disease seems to be assuming epidemic proportions is it worthwhile to isolate the causative strain and take steps to prepare a vaccine.

Treatment in these diseases must concentrate on relief of symptoms, since no therapeutic agent has been discovered which will affect the virus. Antibiotics are of no value.

Below: One of the most popular exhibits at academy meeting was this which demonstrated a technic used to detect blindness and measure visual acuity in very young infants. The display was the work of John J. Gorman, M.D., and Sydney S. Gellis, M.D., both of the Boston University School of Medicine. The method involves exposing the infant or child to the passage of a graded series of line patterns, some of which, when moved across the visual field, evoke an optico-kinetic response. This response consists of an eye movement complex which closely resembles that of vestibular nystagmus.



However, when there is a problem in identifying the causative agent as viral or bacterial, antibiotics should be given at the beginning of treatment. These agents are also valuable as prophylaxis against a secondary infection.—*Horace L. Hodes, M.D.*, pediatrician-in-chief, and *Lotte Strauss, M.D.*, associate attending pathologist in pediatric pathology, both of Mt. Sinai Hospital; *Frank L. Horsfall, Jr., M.D.*, vice-president and physician-in-chief, Rockefeller Institute for Medical Research; *Harry M. Rose, M.D.*, associate attending physician, Presbyterian Hospital; *Robert Ward, M.D.*, visiting physician, Children's Division, Bellevue Hospital; all of New York City.

Preston A. McLendon, M.D. (l.) Washington, D. C., chairman of the academy's committee on juvenile delinquency, discusses with N. H. Cooper, M.D., director, Community Health Council of Greater New York, plans to help delinquents.

Only One Infant Death Reported In New York Asian Flu Epidemic

Infant mortality did not rise during the 1957 Asian influenza epidemic in New York City. Only one of the 216 deaths reported from the epidemic was an infant.

Approximately 10 percent of the city's population was affected, children more so than adults. The epidemic began in June, but did not reach its peak for children until October 2, and for adults, until October 16.

Large industries reported absenteeism as high as 150 percent of the normal rate. School absences jumped from a normal of 6.8 percent to 36 percent.

Deaths from the disease were chiefly in older people, —particularly those with chronic disease. In the younger age groups, pregnant women and persons with rheumatic heart disease appeared to run a greater risk of death.

Infant reactions to Asian flu inoculations were much more severe than those of adults. Because of that, and the fact that infant mortality did not rise during the epidemic, it is not recommended that infants be

(Continued on next page)

inoculated against this strain of virus.—*Morris Greenberg, M.D.*, director, Bureau of Preventable Diseases, New York City Department of Health.

Eye Discharges Reduced in Newborns When Silver Nitrate Discontinued

Four Cases of Ophthalmia Found In Five-Month Period of Study

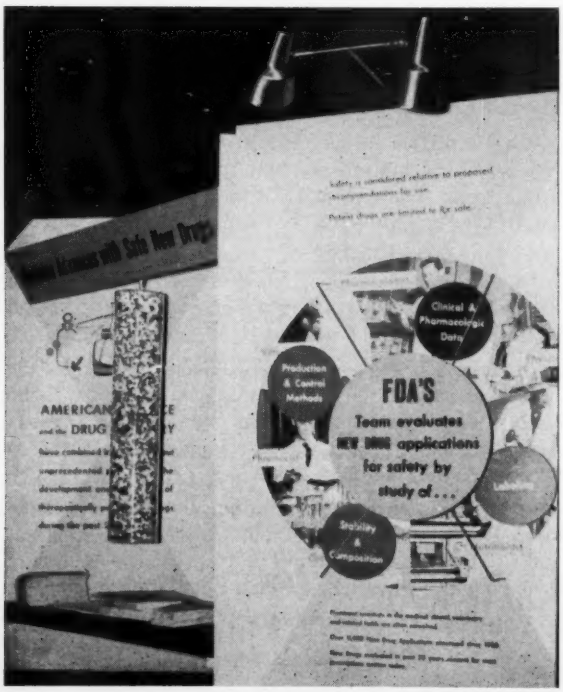
Silver nitrate prophylaxis for gonorrheal ophthalmia neonatorum was discontinued at Sloane Hospital, Columbia-Presbyterian Medical Center for a five-month period in an effort to reduce eye discharges caused by the medication.

One percent silver nitrate prophylaxis had been used in the hospital from January, 1932, to April, 1957. During that period, 10 cases of gonorrheal ophthalmia neonatorum were discovered among 75,775 live births.

From April to October 25, 1957, silver nitrate prophylaxis was discontinued. Cases of eye discharge fell to a rate of 3.2 percent. In cultures, the bacterial flora of the discharging eyes was found to be little different from that of non-discharging eyes. However, positive cultures of *Neisseria gonorrhoeae* were found in four cases.

None of the mothers of the infected children had symptoms or gave a history of symptoms of gonorrheal infection. However, two of the four were found later to have positive vaginal cultures.

Only two of the cases of ophthalmia were noted clinically in the hospital nursery. The third was found after the child was discharged on the fourth day; the last case was discovered in a routine culture of a minor discharge, taken on the eighth day postpartum. All of the children were treated without subsequent difficulties.



The study was discontinued and the use of one percent silver nitrate resumed, pending further investigation of the role of prophylaxis versus that of adequate treatment.—*Gilbert W. Mellin, M.D.*, associate in pediatrics, Columbia College of Physicians and Surgeons, and assistant attending pediatrician, Babies Hospital and Vanderbilt Clinic, New York City.

Enjoying a chat between sessions are Stewart H. Clifford, M.D. (l.), Brookline, Mass., out-going president of the academy, and Horace L. Hodes, M.D., pediatrician-in-chief, Mt. Sinai Hospital, New York, and clinical professor of pediatrics, Columbia University, New York. Dr. Hodes spoke during sessions on viral infections of the respiratory tract.

Staphylococcal Infections Called Constant Hospital Hazard

Change in Host-Parasite Relationship Is Cause for Disease Epidemics

Staphylococcal infections will continue to be a hospital hazard because the causative agents are always present in the hospital atmosphere. The strains which cause hospital epidemics, however, are no different from those present in average surroundings and no more virulent.

One hypothesis explains the greater frequency of staphylococcal infections in hospitals today as the result of a greater prevalence of "epidemic strains," endowed with greater virulence. But evidence has failed to demonstrate that strains causing hospital epidemics are in reality more virulent or that the incidence of staphylococcic infections in normal individuals has increased.

Potentially pathogenic staphylococcus is a ubiquitous organism, even in normal newborns. There has been a change in staphylococcus strains in hospital populations in that they show a higher incidence of resistance to antibiotics.

However, the greater frequency of staphylococcal infections in hospitals is the result of changes in the

Left: Scientific exhibit titled "Medicine Advances with Safe New Drugs" acquaints physicians with the public health protective activities of the Food and Drug Administration as they relate to the development and introduction of new drugs. It was prepared by Irvin Kerlan, M.D., John W. Nesbitt, M.D., and Albert H. Holland, Jr., M.D., all of the Department of Health, Education and Welfare, Food and Drug Administration, Washington, D.C.

host which upset the normal balance between parasite and host. Factors include lowered resistance in patients already ill, greater susceptibility of infants, and readily available entrance ways such as open wounds and sites of medical injections.

Universal use of prophylactic drugs is not the solution since these strains are attacking only the most defenseless patients in highly selective areas. The following rules are recommended for guarding against epidemics:

1. Hospital personnel and physicians should recognize that staphylococcal infections are a constant hazard; potentially, infection may break out from any source. Constant vigilance must be maintained as well as preparations for action if an infection does occur.

2. When an outbreak is discovered, immediate concerted action must be taken by hospital personnel, physicians, and public health groups, to isolate the cause and eradicate the infection.

For example, if an outbreak occurs in the nursery, complete isolation of the unit should be established; thorough laboratory tests should be conducted on equipment, supplies, and personnel in the area.

Since no one group can carry out the drastic measures necessary to prevent the further spread of the infection, the whole hospital must act as a team to put into effect an emergency program of control.—*Hattie E. Alexander, M.D.*, attending pediatrician, Babies Hospital; *Peter Dineen, M.D.*, assistant attending surgeon, New York Hospital; *Walsh McDermott, M.D.*, professor, public health and preventive medicine, and *David E. Rogers, M.D.*, associate professor of medicine, both of Cornell University Medical College; *Frederick H. Wentworth, M.D.*, acting chief, division of communicable diseases, Department of Health, Columbus, Ohio.

Three members of a panel which discussed staphylococcal infections are (l. to r.): Hattie E. Alexander, M.D., attending pediatrician, Babies Hospital, New York City, and associate professor of pediatrics, Columbia University, moderator; Walsh McDermott, M.D., attending physician, New York Hospital, and professor, public health and preventive medicine, Cornell University Medical College, New York City; and Frederick H. Wentworth, M.D., acting chief, division of communicable diseases, Department of Health, Columbus, O.

Premature Infant Subject to Two Different Types of Anemia

One Is True Iron Deficiency Anemia

Two distinct types of anemia may affect the prematurely born infant during the first six months of its life. These differ in pathogenesis, time of occurrence, and type of prophylaxis or therapy required.

The early anemia of premature infants results primarily from a marked diminution in blood formation. Beginning almost immediately after birth, it continues for five to eight weeks and is not modified by administration of iron. The majority of infants, however, improve without specific therapy or transfusion.

The second type of anemia occurs at three to six months of life and is a true iron deficiency anemia resulting from exhaustion of initial reserves of iron.

The iron demands for optimal hemoglobin synthesis in the rapidly growing premature infant are such that an adequate supply cannot be obtained from dietary sources alone.

When iron supplementation will be needed, and the amounts which will be required, will depend on birth weight, rate of weight gain, hematopoietic capacity, and most important, the initial hemoglobin mass at birth.—*Irving Schulman, M.D.*, associate professor of pediatrics, Cornell University Medical College, and assistant attending pediatrician, New York (N. Y.) Hospital.

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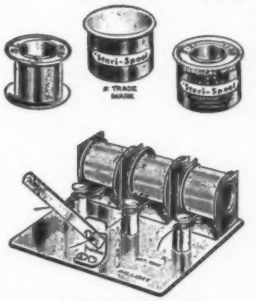

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1. Grossman, L.: Archives of Pediatrics, 71: 173—179, June 1954.

ANOTHER FINE PEDIATRIC SPECIALTY BY BREON

Obstetricians Stress Methods of Improving Patient Relations

OB DEPARTMENT

TOPICS covers Sixth Annual Meeting, American College of Obstetricians and Gynecologists, April 21-23, Los Angeles

Better Medico-Legal Precautions Can Reduce Malpractice Suits

New Form of Insurance Suggested To Cover 'Untoward Results'

To prevent the increasing number of suits being filed by patients against doctors and hospitals, clearer and better relations should be established with patients. They must understand fully what is being done for them.

Paradoxically, the more that advances in medicine and surgery are publicized, the more the patient demands. If she is disappointed, her first thought is to sue. The patient and her immediate family should know the nature and extent of the treatment involved and the exact hazards in the situation. This creates an honest, confident relationship. If something does go wrong, the doctor should explain what and why.

Several safeguards can be employed against suits. Hospital staff meetings should be held to discuss ways of improving patient relations. The hospital should make sure that the patient *reads* the full, thorough consent statement, covering all eventualities, before she signs it. Any tissue removed in surgery should be examined and photographed, then discussed with the patient, so she cannot come back later with any charges.

The anesthetic to be used should be discussed with the patient. Better records should be kept by both doctors and hospitals, in case they should ever need to be read to a judge and jury. The specific information in good records can make or break a malpractice suit in court.

An insurance plan has been suggested to protect hospitals against "untoward results" such as a bacterial infection contracted by the patient during hospitalization, in which there was no fault, no lack of reasonable care by the hospital. The patient could pay for the insurance at a rate of $1 or $2 per $100 of the hospital bill; handling would be much like that of airplane flight insurance.

In California, which leads the nation in number of malpractice suits (500 filed yearly), an attempt is being made to prevent cases without merit from reaching court, where the resulting publicity stigmatizes the doctor and/or hospital. The Los Angeles County

(Continued on next page)

Jack A. Pritchard, M.D. (r.), chairman, department of obstetrics and gynecology, University of Texas Southwestern Medical School, Dallas, stops at scientific exhibit demonstrating electronic method of timing birth intervals. Schuyler G. Kohl, M.D., State University of New York College of Medicine, Brooklyn, explains the mechanism, which he developed with the co-operation of Airborne Instruments, Inc., engineers. Device accurately records breathing and crying times in several delivery rooms. Permanent record is produced for filing with mother's and baby's individual records. Charts at exhibit demonstrated how timing mechanism has been used to evaluate analgesic and anesthetic agents.

Above: Following conference, W. R. Roy, M.D. (l.), Topeka, Kans., compares notes with William E. Strozier, M.D., San Antonio, Tex. Right: Two of breakfast conference leaders are: Ernest W. Page, M.D. (l.), chairman, department of obstetrics and gynecology, University of California, San Francisco; and Clayton T. Beecham, M.D., chief, tumor service, Temple University Hospital, Philadelphia.

OB DEPARTMENT continued

Medical Association has set up a committee of doctors and lawyers to evaluate the merits of the proposed suit. The medical specialists on the panel act as counsel for the plaintiffs, discuss the case with the defense, then, if the case appears to be legitimate, make themselves available as expert testimony witnesses. The California State Bar Association is setting up a similar committee on a state-wide basis, and many communities in other states are finding this effort worthwhile and emulating it.

The number of malpractice suits could be reduced if attorneys investigated the facts before filing. Such investigation should include a thorough study of hospital records, particularly those dealing with surgery, the physician's office records, and honest consultation with another doctor not involved in the case.—*William Benbow Thompson, M.D.*, clinical professor of obstetrics, University of California Medical Center, Los Angeles; *Melvin M. Belli, LL.B.*, attorney, San Francisco; *Ludwig A. Emge, M.D.*, emeritus professor, department of obstetrics and gynecology, Stanford University School of Medicine, San Francisco; *Harold J. Hunter, LL.B.*, attorney, Los Angeles; *Richard L. Kirtland, LL.B.*, associate professor of legal medicine, College of Medical Evangelists, Los Angeles.

Q. Should a suit be filed if a patient received an incompatible blood transfusion, yet later made a full recovery?

A. Did the laboratory responsible exercise reasonable care? Mistakes are bound to be made, but if reasonable care was exercised, there is no liability.

Q. Does an honest error in judgment constitute basis for a malpractice suit?

A. Yes, because all malpractice suits are caused by errors in judgment.

Q. What is the responsibility of an obstetrician to attend the patient's delivery? If an intern delivers her before the physician arrives, is that physician negligent?

A. It is a question of degree. If he is delivering at another hospital, or is held up in traffic, a jury would not convict him. But if he left the state—on a vacation, for instance—without leaving specific instructions for the care of his patient, and trouble ensues, he is guilty.

Calls for Greater Caution in Choice And Use of Obstetrical Anesthesia

Anesthetics Now Rank Fifth As Cause of Fetal Mortality

With the present-day use of antibiotics, blood transfusions, cesarean sections, and better prenatal care, many of the previous causes of fetal and maternal mortality have been removed, leaving anesthesia fifth-ranked as a cause of mortality during childbirth. Forty percent of stillbirths are due to anoxia.

A careful examination of the types of anesthesia and analgesia available for use during childbirth, and closer observance of safety rules, will provide relief technics least dangerous to mother and child.

Consideration must be given to the expected duration of labor, and the patient's medical history and present physical condition, in making the choice between regional, inhalation, parenteral, oral, or rectal anesthesia. Causes of accidents with anesthetic agents are, basically, erroneous choice of agent, and faulty judgment in technic of administration.

An essential rule for safe administration of inhalation or regional anesthesia is to have the following immediately available: equipment for administering oxygen or negative suction, endotracheal tubes for ventilation, and pressor drugs.

Contraindications to spinal anesthesia are: any history of central or peripheral nervous system injury, previous back injury, or surgery; presence of shock, hemorrhage, severe hypotension or hypertension; a need for maximal relaxation of uterus: fear or reluctance on the part of the patient.

The trend in obstetrical analgesia is away from the use of profound narcotics, and toward the balanced use of several drugs to obtain the advantage of a summated therapeutic effect. Smaller doses given with greater frequency have proved practical for increasing pain relief.

In premature labor, when barbiturates and narcotics are contraindicated, caudal anesthesia has proved most useful, eliminating heavy pre-sedation and producing a higher fetal "salvage rate."

Mental and psychological pre-education to relieve fear aids relaxation. If started sufficiently early in

Enjoying a morning coffee break in the hospitality room are (l. to r.): A. W. Bostrom, Jr., M.D., Yakima, Wash.; Joseph T. Velardo, M.D., assistant professor of medicine, and D. W. Hess, M.D., associate professor of medicine, both of Yale University School of Medicine, New Haven, Conn.; and D. A. McKinnon, M.D., Sacramento, Calif.

pregnancy, such education proves useful in the labor room and reduces the necessity for analgesia. Patients like full information on the various types of anesthetics and analgesics available, and they should be given their own choice as far as possible.—*Donald W. de Carle, M.D.*, associate clinical professor, Stanford University Medical School, San Francisco.

Pitocin Safe, Satisfying, in Both Elective, Indicated Labor Induction

Reduces Necessity for Cesarean Section Shortens Labor, Savies Babies

The judicious use of pitocin to induce or stimulate labor will save babies, shorten labor, and reduce the necessity for cesarean section to the absolute minimum.

When the proper time is chosen and contraindications are observed, elective induction of labor with pitocin is safe and satisfying. Indicated induction with pitocin is more traumatic, complications more numerous and severe, and the cesarean section rate necessarily higher, but this technic is still preferable either to other methods of induction or to cesarean section.

These conclusions are the result of a study in which 18.4 percent of all patients delivered at the Hospital of the University of Pennsylvania from January, 1950, through December, 1957, received intravenous pitocin for induction or stimulation of labor. The technic included amniotomy, in all patients with intact membranes, shortly after pitocin was started.

Pitocin was used electively 2,933 times; it was used when induction was indicated in 387 cases. Complications included spasm of the uterus, fetal distress, postpartum hemorrhage, premature separation of placenta, prolapsed cord, and cervical laceration.

In stimulation of labor, the low incidence of complications and of traumatic deliveries leads to the conclusion that early pitocin administration is worthwhile in the absence of contraindications.—*Harry Fields, M.D.*, assistant clinical professor, obstetrics and gynecology; *John W. Greene, Jr., M.D.*, instructor and research fellow, department of obstetrics and gynecology; and *Robert R. Franklin, M.D.*, resident, obstetrics and gynecology; all of the Hospital of the University of Pennsylvania, Philadelphia.

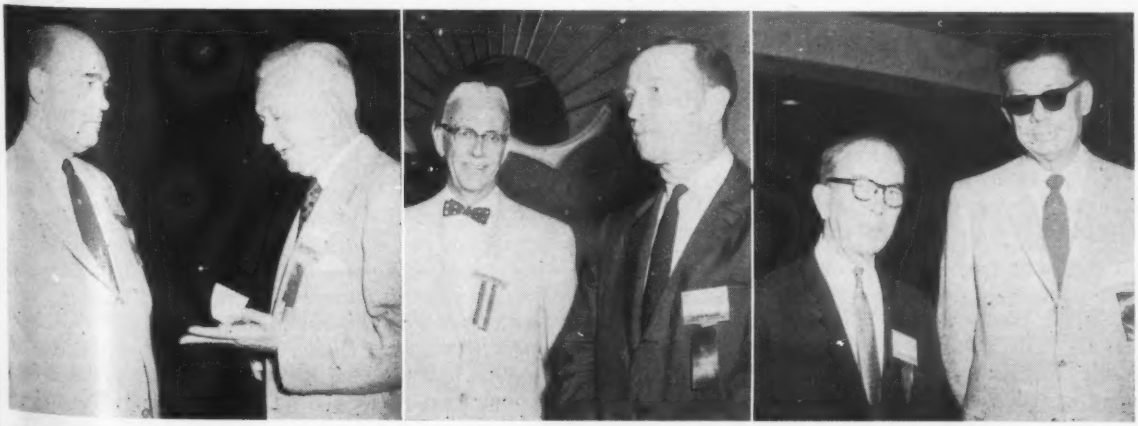
Pitocin, Caudal Anesthesia Combination Found Effective in Prolonged Labor

We have been using caudal anesthesia and pitocin in cases of prolonged labor and find it effective in relaxing the cervix and starting delivery. We believe this technic has eliminated the necessity for cesarean section in many instances.

It is necessary to have adequate personnel available for administration. At the Hospital of the Uni-

(Continued on next page)

College officials for 1957-58 gather before annual business meeting: Left—president-elect R. Glenn Craig, M.D. (r.), San Francisco, with John Parks, M.D., Washington, D.C., first vice-president; Center—Ralph E. Campbell, M.D. (l.), Madison, Wis., immediate past president, with Kenneth T. MacFarlane, M.D., Montreal, Que., Canada, second vice-president; Right—R. Gordon Douglas, M.D. (l.), New York City, president, with Herbert E. Schmitz, M.D., Chicago, treasurer.



Charles S. Kasdon, M.D. (l.), associate professor, department of obstetrics and gynecology, Tufts University School of Medicine, Boston, discusses his paper on management of cancer of the cervix with Russell R. de Alvarez, M.D., professor and executive officer, department of obstetrics and gynecology, University of Washington School of Medicine, Seattle, who presided at session.

OB DEPARTMENT continued

versity of Pennsylvania, a medical student watches the patient, checking her every 15 minutes. The OB resident administers the caudal anesthesia, but an anesthetist stands by during delivery for extra safety.

Patient labor is considered prolonged if it exceeds 24 hours. Sedation is begun when the patient enters the hospital. If a period in delivery is reached when there appears to be no further progress and the cervix continues rigid, caudal anesthesia is initiated. Then, if no progress ensues within one-half hour, intravenous administration of pitocin is started.

When using this combination, we wait 24 hours, and in a few cases 30 hours, before performing a cesarean section.

For adequate analgesia, we administer 15 mg. of morphine when the patient enters the hospital. Later, if she is not resting well between pains, we supplement this dosage with additional morphine. Barbiturates do not give adequate sedation, provide no pain relief, and make the patient restless.—*Robert C. McElroy, M.D.*, assistant professor of obstetrics and gynecology, School of Medicine of the University of Pennsylvania, Philadelphia; and *Robert W. Preucel, M.D.*, Philadelphia.

Study Finds Hypoxia, Death of Fetus Are Dangers in Postdated Gestations

Onset of Labor Should Not Be Hastened If Placental Function Is Normal

The incidence of hypoxia in postdated fetuses was 22 percent higher than normal in a study of 5,572 deliveries at Johns Hopkins Hospital, Baltimore, between 1950 and 1954. Mortality of postdated fetuses before labor was almost twice as high as normal, while during labor, it was more than six times as high.

Because of the possibility of hypoxia, the onset of labor should not be hastened in postdate patients if placental function appears to be normal. However, a toxemic patient should not be allowed to postdate delivery, because an inadequate placenta is to be expected in such patients.

Fetal distress can be judged, before delivery, by a fetal heartbeat below 100 or over 160. After delivery, meconium stain is present, and blood samples show low oxygen saturation.

The Johns Hopkins studies disprove fears of cephalopelvic disproportion in postdatism — that is, when gestation is prolonged more than 294 days. In these studies, the infant was not found to enlarge appreciably in the postdate period; the birth weight varied only 100 grams between mature and postmature fetuses. The incidence of labor complications was not significantly higher in prolonged gestations.

Because postdated gestation occurs more frequently in primaparous women over 35, special care must be taken in the delivery of such patients to guard against hypoxia. Pitocin should not be used, analgesia should be lessened, and obstetric trauma minimized. Hydration, rest, and even cesarean section are preferable to the use of pitocin to combat uterine inertia in such patients.—*Robert E. L. Nesbitt, Jr., M.D.*, professor, and director of education and research in obstetrics and gynecology, Albany Medical School of Union University, Albany, N.Y.

Patient Education Needed In Sterilization Surgery

Cooperation of Hospital Staff Required For Wholesome Mental Adjustment

Promoting wholesome attitudes and emotional reactions in a patient undergoing surgery resulting in sterilization requires the combined efforts of hospital staff, doctor, husband, and family.

To minimize apprehension about after-effects, prevent psychosomatic feelings of greater pain after surgery, and quiet popular misconceptions about results, patient education should begin early, in the doctor's office. The patient should fully understand preoperative procedure and should have the opportunity to discuss various anesthetics with the anesthetist. She should be helped to realize that hysterectomy, ovariectomy, or tubal ligation will not de-feminize her but rather will relieve pain and anxiety.

Operative findings should be discussed with the patient after she has partially recovered, particularly in a question of malignancy.

Individual hospital rules regarding sterilization and the laws of the state are important factors in the decision to perform such surgery. Eleven states have laws preventing tubal ligation.

In determining necessity for surgical sterilization, the following are generally considered to be valid reasons: organic illness; three cesarean sections; an age of more than 32 years with a demonstrated failure of nonsurgical contraception.—*Allan C. Barnes, M.D.*, professor and chairman, department of obstetrics and gynecology, Western Reserve University, Cleveland, O.; *Waverly R. Payne, M.D.*, chief attending gynecologist, Riverside and Mary Immaculate Hospitals, Newport News, Va.; *Frederick P. Zuspan, M.D.*, chief of clinical services and of department of obstetrics and gynecology, McDowell (Ky.) Memorial Hospital.

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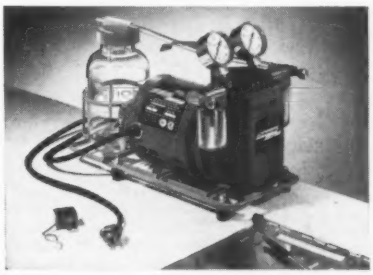

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- Discusses pertinent facts which guide members of the operating room team to establish a care plan for patients; shows the relationships of the sciences to operating room practices; shows how these practices are related to preoperative and postoperative care.
- Helps the reader develop an appreciation of the scientific principles underlying surgical techniques and a nursing care plan peculiar to each patient and his disease.
- Reviews basic principles of microbiology as they apply to surgery, clinical and physical disinfection and sterilization of equipment.
- Studies the application of the concepts of medical and aseptic principles, stressing the safety of patients and personnel and the aesthetic and psychologic needs of patients.
- Includes pertinent information, advice and contributions supplied by the following distinguished surgeons: Dr. Earle Spaulding, Dr. Fremonte Peck, Dr. George R. Brighton, Dr. Walter Wichern, Dr. Scudder Winslow, Dr. Howard Patterson, Dr. Thomas Peightal, Dr. Simon Beisler, Dr. William Nelson, Dr. Rolla Campbell, Dr. William Littler and John Perkins.

Not only has this book been broadened in scope and retitled, but each chapter has been extensively revised. New techniques and new procedures in neurosurgery, circulatory and respiratory systems and orthopedic conditions have been added along with a brief review of the anatomy and physiology involved.

Certainly a "must" for every member of the surgical team—for the nurse, surgeon and administrator who directly or indirectly comes in contact with the surgical patient, this well-written and well-illustrated volume comprehensively discusses every aspect of preoperative, operative and postoperative care. Why not order this book today. Discover for yourself how valuable it can be in helping you meet your responsibilities and in fulfilling the expectations of the patient, the surgeon and your co-workers.

By EDYTHE LOUISE ALEXANDER, R.N., B.S., M.A., Director of Nursing Service and Principal of the School of Nursing, Lutheran Medical Center, Brooklyn, New York; Formerly, Supervisor of Operating Rooms and Associate Director of Nursing Service at the Roosevelt Hospital, New York; Formerly Supervisor at Mountainside Hospital, Montclair, N. J., and of the Private Pavilion Operating Rooms, New York Hospital, New York, N. Y.

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Name Medical School Dean

Hugh H. Hussey, Jr., M.D., will become dean, Georgetown University School of Medicine, Washington, D.C., on July 1. Dr. Hussey has been professor and head of the department of medicine at the university.

Blue Cross Establishes Memorial Award

E. A. van Steenwyk, executive director, Associated Hospital Service of Philadelphia, has been named the first recipient of the Justin Ford Kimball Award, established by the Blue Cross Commission to honor "outstanding encouragement given to the concept of prepaid voluntary health care plans."

The award, a medal and certificate, is a memorial to Dr. Kimball, founder of the first health prepayment plan, in Dallas, Tex. It was presented to Mr. van Steenwyk in a luncheon ceremony during the annual conference of Blue Cross plans, held in Chicago in April.

AMA Director Resigns

Thomas H. Alphin, M.D., has resigned as director, Washington Office, American Medical Association, to become associate medical director, Equitable Life Assurance Society, New York City.

William J. Kennard, M.D., formerly deputy director, has been named acting director of the office.

Expand Advisory Program For Bureau of Standards

The National Bureau of Standards, federal research laboratories, and the National Academy of Sciences-National Research Council, nongovernment organization of research scientists, have announced an expanded plan for coordination of the bureau's advisory committee program.

Advisory groups have been coordinated by the Academy-Research Council. Under the new plan expanding advisory activities, major scientific societies will nominate representatives to serve as advisors to the bureau.

From this group, the council will assemble advisory panels, each one responsible for evaluating a particular segment of the bureau's work.

The Book Corner

MODERN PHARMACOLOGY AND THERAPEUTICS. By Ruth D. Musser, M.S., and Joseph G. Bird, M.D. New York: The Macmillan Company. 1958. 828 pp. $6.75.

Designed as a practical text for the study of basic pharmacology, this volume is adapted primarily for the nursing student, but will also be useful to other students in related fields.

In the text, the subdivisions of pharmacology are explained; the chapters are grouped into functional units to aid in correlation of the organized material. Recent advances in pharmacology and new agents are covered as thoroughly as possible, and the clinical background of many of the pathological conditions for which the agents are used is included as an aid to the nurse's understanding of her role in administering medication.

DYNAMIC ANATOMY AND PHYSIOLOGY. By L. L. Langley, Ph.D.; E. Cheraskin, M.D.; and Ruth Sleeper, R.N. New York: The Blakiston Division, McGraw-Hill Book Company, Inc. 1958. 719 pp. $6.

This textbook provides a different approach to the study of anatomy and physiology. The authors point out, in their preface, the changing emphasis in the healing arts and explain:

"Anatomy, both gross and microscopic, is now recognized, not as an end in itself, but rather as a prerequisite for the comprehension of physiology, which in turn is essential for the total understanding of the human body.

"This textbook breaks with tradition. Not only is anatomy reduced, but the study of function—that is, physiology—is at all times integrated into the broader considerations of the student's major goal."

The book is arranged for the use of nursing students, but can be adapted to junior college or college courses as well.

Illustrations include a color atlas of the human body, a photographic series on the development of the human embryo, and photographs of human models on which various muscles are labeled.

SO YOU'RE GOING TO RAISE FUNDS. By David M. Church. New York: National Publicity Council for Health and Welfare Services, Inc. 1957. 56 pp. $1.25.

Another in the National Publicity Council's "how-to-do-it" series, this booklet provides a practical guide to fund raising. It is designed to help anyone concerned with such campaigns, offering material for the professional as well as the amateur.

The author, executive director of the American Association of Fund-Raising Counsel, Inc., presents the fundamental factors essential to all fund raising campaigns and outlines basic procedures which may be adapted to large-scale campaigns or small fund-raising efforts.

Copies are available for the purchase price, $1.25, plus 8 cents postage, from the National Publicity Council. 257 Fourth Ave., New York 10, N. Y.

Everybody's talking about Staph...

. . . and with good reason. Staph is a *real* trouble maker. Staphylococcus aureus—to be more formal—is vicious. It invades every part of the hospital. Wherever there are people, it can multiply. In dust, staph lives for weeks waiting to re-infect.

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(Editor's note: In fact, staph infection can pave the way for strep infection, too. If strep gets into a wound with antibiotic-resistant staph . . . parenteral penicillin won't stop or prevent strep infection even when the strep organisms are penicillin sensitive.)

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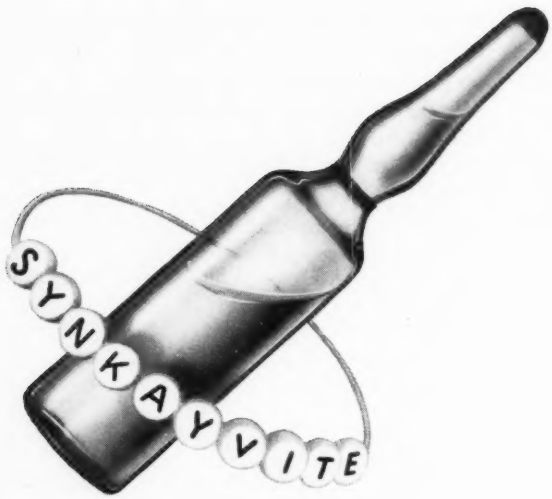

Newly born for the Newborn

Recent clinical reports (J.A.M.A. *164*:1331, July 20, 1957) have stressed the adequacy of low doses of water-soluble vitamin K analogs for infants and especially the undesirability of excess dosage in prematures. So you will be glad to know of these two new dosage forms of Synkayvite:

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clinical notes

Lysine Found to Increase Gastric Juices Activity

High dosages of the protein constituent, lysine, substantially increase the activity of gastric juices, state Sackler and Sophian in the *American Journal of Clinical Pathology* 28:253-63 (October, 1957).

Investigating the effects of single amino acids on the body, the authors gave 5 Gm. lysine with a test meal of bread to 21 healthy adults. The result was a substantial increase in pepsin activity and a moderate, less constant rise in concentration of hydrochloric acid in 18 subjects.

The 5-Gm. dose of lysine, 10 to 20 times the amount usually used in diet supplements, was well tolerated. Blood levels of lysine did not change. Lysine, itself, does not appear to have peptic or hydrochloric activity, the authors state; rather, it appears to stimulate secretion of the gastric mucosa.

The authors point out that use of lysine to correct imbalance of amino acids in natural food substances may become commonplace in the near future.

Control of CNS Symptoms In Aged Arteriosclerotic

Success in controlling many of the symptoms of arteriosclerotic disease of the central nervous system in aged patients is reported by Kapernick in *Geriatrics* 12:703-08 (December, 1957).

Over a 10-year period, the author administered Metrazol* to 687 patients, each of whom was observed for an average of two and one-half years. Of these, 206 had a history of "small strokes," 72 had primary psychiatric disorders, and many were essentially disabled by insecurity, weakness, and varying degrees of withdrawal. All were noninstitutional patients without severe hypertension, diabetes, or serious head injury.

The drug was given to cooperative patients in doses of from 4.5 to 12 gr. daily. Non-cooperative patients were given up to 18 gr. daily, in injections. In the latter, oral treatment was instituted as soon as practical, in an average dose of 9 gr.

The author observed good to excellent results in 574 patients, or 83.5 percent; 82 patients, or 12 percent, he classified as failures because of lack of evidence of significant improvement; and an additional 31 patients, or 4.5 percent, he labeled failures because of their inability to tolerate medication or willingness to discontinue it, indifference to dosage schedules, or favorable reactions to placebos.

Because of improvement in sleep pattern, social adaptability, subjective feeling of well-being, freedom from symptoms, and lessening of disability, the author concludes that this therapy appears to be a safe and useful adjunct for treatment of the arteriosclerotic patient.

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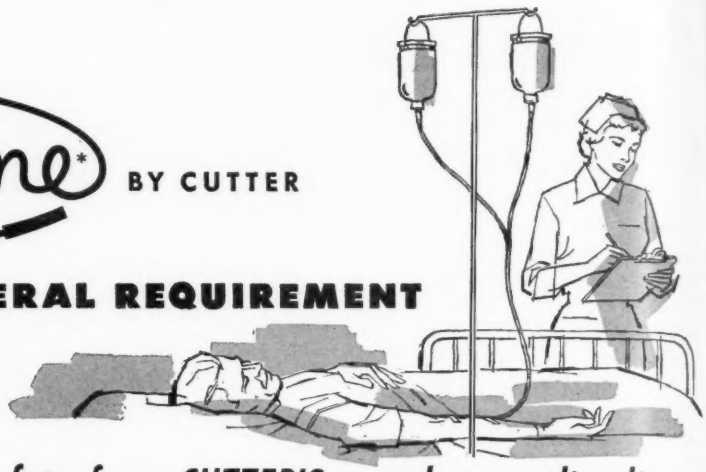

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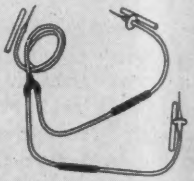
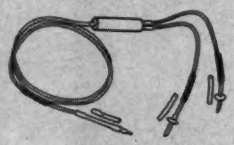
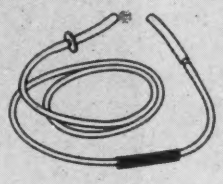
Saftiset "Streamliner"* I.V. Infusion Set	**Safticlysis*** Hypodermoclysis Injection Set	**Saftifilter "Y"*** Blood and Plasma Y-Tube Set	 **Saftidonor "Y"*** Blood Donor Y-Tube Set
 **Saftiset "Y"*** I.V. Infusion Y-Tube Set	**Saftifilter*** Blood and Plasma Infusion Set	 **Saftidonor*** Blood Donor Set	**Pediatric Scalp Vein Infusion Set**

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HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

AORN GROUP FORMED FOR TWO TEXAS COUNTIES

A NEW AORN group, formed in Texas early this year, launched its program under newly elected officers at a dinner meeting in April in Beaumont.

The Association of Operating Room Nurses of Jefferson and Orange Counties, Texas, was organized on January 8. Guiding its activities are (above, l. to r.): Mrs. Dolores Cleaver, Orange Memorial Hospital, treasurer; Mrs. Pat Hebert, Hotel Dieu, Beaumont, vice-president; Mrs. Sally Manderson, Baptist Hospital of Southeast Texas, Beaumont, president; and Mrs. Theresa Flood, St. Therese Hospital, Beaumont, secretary.

Members of the new association who attended the meeting are shown in the photograph on the following page.

Other nurses who took part in the organizational meeting are shown above, with guests, at dinner. They are (table at left, l. to r.): H. R. Wilcox, M.D., Mrs. Dolores Vallot, Mrs. Simone Douthe, Mrs. Pearl Younger, Adele Borel, Mrs. Kenneth Miller, Mrs. Bernice Sturrock, Mrs. Majorie Aimsworth, Mrs. Phyllis Kilpatrick, Vita Mae LaSalle and Mrs. Bettie Lou Pillsbury. At the table at right are (l. to r.): Mrs. Marian Androws, Mrs. Doris Van Benthuysen, Mrs. Laura Matheney, Mrs. Dolores Wright, Mrs. Shirley Williams, Cora Madeline Williams, Mrs. Mary Page, Mrs. Kenneth Hynes, B. C. Darnell, M.D., Mrs. J. D. Poole, Mrs. Bessie Smith, Mrs. Hazel Courts, Mrs. Marylin Dorsey, Patty Williams and Mrs. Mauverine Crouch. At the speakers' table in back of room are (l. to r.): Mrs. Pat Hebert, Mrs. Sally Manderson, Mrs. Theresa Flood and Mrs. Dolores Cleaver. The nurses are from Beaumont, Port Arthur, and Orange, Texas.

Communications—a Two-Way Street

By Edmund Kowalczyk*

• Communications is basically a problem of interpretation, and getting messages. The whole definition of communications as I see them is: "The action, or lack of action, that takes place as the result of exchange of thoughts, ideas, or emotions."

Here is one example of a situation in which I missed the message, without any question, and I didn't know I missed it at the time. It occurred in Chicago, at a conference of supervisors of our company's two plants, from New Brunswick and Chicago. I had a dual capacity on the program. I was partly in charge of the preparation of the program, and I also was one of the speakers.

I sat down next to a man who had a very modest position in the company. He kept pointing to a favor that we had prepared for everyone in the organization. It was a little circular ash tray. On the synthetic leather around it, the man's name was embossed.

As I looked at this man I saw a joyful look on his countenance. He felt wonderful; he kept pointing to this ash tray. Then suddenly his countenance fell a little bit, and he said to me, "Ed they've got my name misspelled." I shrugged this off; I said to myself, "This man is a very nice fellow, but I have a thousand and one details, and he is griping to me about the fact that his name is misspelled!"

So I said: "I'll take care of it. Don't mind me, I'm busy right now, but I'll give it my full attention." By the tone of my voice he knew that this would be done—some day—maybe.

The next day it was my turn to get up on the podium and present my particular part of the talk. I talked about human relations. I felt particularly good, and I pulled out all the stops. I ranted, I raved, I slapped the podium. I talked about empathy, and participation, and seeing the other person's point of view. I quoted from authorities, and I made up a few of my own. When I finished, the applause was music to my ears. Many people were kind enough to come up and shake my hand after the talk and say: "Ed, that was a very good talk. You outdid yourself—it was wonderful!"

*Personnel director, Ethicon, Inc., Chicago. This article and the following one by Dr. Planty are adapted from lectures given at the recent fifth national congress, Association of Operating Room Nurses, in Philadelphia.

This little man sitting next to me said: "Ed, that was a marvelous talk, but my name is still misspelled on my ash tray."

He was telling me the most powerful message that I've ever heard in communications. In effect, he said, "You can talk until Doomsday, but 'By their acts ye shall know them.'"

One of the great principles that we can elicit from this particular story is that one of the great ideas behind all communications is the reputation that you earn by following your thoughts and words with action.

There is a tyranny of words that we have to be very careful about, because speech itself is very deceptive. On the wall of an automatic elevator in a Philadelphia hotel was a little label which said, "Operatorless elevator." The three of us in the elevator tried to decipher the meaning of these two words. To one man, they said that this was a car minus an operator, and that one might appear sooner or later. Another thought that they were another way of saying, "automatic elevator," while the third man conjured up all kinds of visions of social injustice such as of some poor elevator operator out walking the cold streets of Philadelphia that day.

Communications is not done with words alone. Movements of the head, body, grimaces, silences, scowls, form a very powerful speech. Married men can attest to the binding power of a wink, which speaks more softly, and with greater binding, than tomes and tomes of words.

The most important aspect of communications is the general underlying principle that it's a two-way street.

Listening is as important as speaking—not only listening, but listening for the message. Here are a few rules for effective listening.

• First of all, you must take time, and have the proper attitudes for listening. The fad nowadays is to listen—no matter how boring the message may be. So we allow a little time in our office, or our place of operation, to listen to people. We think we're listening to these people, and we're doing the right thing.

But as we're doing this, we're shuffling our papers; we're looking up at the ceiling; we're indicating to this person in many ways that we're not listening; we'd rather be some other place. We're saying, "We don't have time for you at all."

The minute the person senses this kind of atmosphere, whatever he wants to say to you becomes modified. Maybe he now raises his voice and becomes angry; he wants attention. Now he is sending a message other than the one originally intended. Make sure that your attitude is one of listening to the message as first intended.

If you're going to listen, take time out to listen, and make it obvious to the person that you're listening.

• Be objective. There is a certain driving type of egotism in many of us that makes it impossible for us to remove ourselves from any situation. Someone comes to us and says: "We've got sickness in our family. We've got three people out with colds; we have a couple of people who have strep throats," and so on. Some of us immediately get into the act and say: "You think you've got troubles? You should see the troubles I have!" This is not being objective.

Try to let this man say the message without your interference. Listen to everything he has to say. People come to us and say one thing—but they mean something else. When they rant and rave and inveigh against circumstances, they don't expect us to do anything about some of these things. They're really saying: "You're a friend of mine; I can let my hair down in your presence, and you'll present to me a sympathetic ear or audience." Many times we misconstrue this as anger against ourselves, and we feel that these people in some fashion are impinging upon our particular status, in a hospital, or whatever the work situation may be, and we stifle this flow.

But they're trying to tell us things—just as the man at the conference was telling me: "The most important things in this conference were not the speeches at all—the most important thing was this ash tray with my name on it! This dignified me as a human being. This made me feel that I was an important part of this particular organization, and you're not paying attention to it!"

When people talk, try to get their real message. What are they trying to tell you?

Do not state your position when you're going to listen, and expect people to fall into line. That's one-way communication. If you state your opinion and expect other people to blindly follow what you say, you have completely misunderstood the process of communication.

• The next rule is to be really open-minded. There are many people who have differing points of view, and a different background, have a different message, and a different way of saying it. Many of us have already typed people over the years. It has often been said that we know the people the least who are with us the most.

• Follow listening with action. Listening by itself is merely an act, an exercise. But the thing that's important is your reputation. Does someone say of you: "If I speak to Mary Smith, I know she'll do something about it?"

Listening does not necessarily mean compliance with the point of view of the person who is speaking to you. You can make a great mistake and do yourself and the listener a great deal of harm if you don't have that principle clear in your mind.

You say that you're going to listen, and as you listen you have a smile on your face and you nod

(Continued on next page)

assent. This is the way you think you should listen. You're doing the wrong thing. You're telling this person, "I agree with you," and perhaps you don't. In fact, maybe you disagree.

When the man or the woman has finished, you should then say: "I have listened to your point of view, and I think it's very well taken; now I want to present another way of looking at it. It's my point of view." Perhaps one of the reasons he talks to you the way he does is that he does not understand your point of view.

But do not appear to agree, if you do not.

IMPORTANCE OF ORDERS

Many of us consider that the whole field of communications really revolves around the order concept. We give orders down to people, and they immediately do them. So a great many of our communications are one-sided and are in this area of orders. Here are a few thoughts about communications as far as order-giving is concerned:

First, think through an order before giving it. To correct my own semantics, I think the proper expression is: "Sharing an order." Then ask yourself what you want to accomplish. What do you want to do? There must be some reason behind your order. Order for order's sake is an authoritarian device.

Anticipate the response. If you feel there's going to be difficulty, then prepare yourself mentally, emotionally, physically, and psychologically for it.

Minimize the necessity for orders; let your objective be self-management. Every one of us working as an entity can do a great deal if given the chance. Orders sometimes inhibit an individual's full scope of ability.

Orders themselves should have certain attributes. First of all, an order should be clear. It should be complete. People hate to work in a piecemeal fashion. They like to know the whole concept of what they're doing. The order should be as positive as possible, and it should not be contradictory. Courtesy should be used in giving orders.

Then there's the basic question you should have asked in the first place about orders: "Am I the person who should give this order?"

This business of sharing an order can become an exciting experience.

To begin with, in almost every hearer there is a conflict between personal and official views of any given circumstance.

Unfortunately, many of us are motivated by selfishness, and almost anything that happens is followed by an inquiry as to, "What good will this do me?" Or, "How do I fit in?"

Then there's an official point of view that we are supposed to do this because our job level is Job Level 8 or 9.

As you are sharing an order with someone, you also discover whether or not there is any resistance to the order. In some cases it's very obvious, such as slamming the door, and throwing something on the floor. But there are more subtle ramifications, negative quotations from philosophy, or remarks such as, "Things aren't what they used to be around here." There are even more subtle variations of resistance. If you listen very carefully, you'll notice them.

Degrees of compliance also indicate reception or nonreception of an order.

People don't particularly care to be told to do something. They want to know why they should do it. That's one principle you should never forget.

Remember, too, that people have various levels of responsibility, and therefore, their resistance will depend upon their responsibilities. Everyone views almost every particular item of communication in the matrix of his own particular job need and responsibility.

There is a great deal of difference in personal backgrounds. Many people are very insecure; many people are calloused; many people have philosophies of life which are counter to ours. There are differences in schooling and education. When you get into communications, which is an exchange of the oral and the written, education of course plays a great role.

There are emotional and prejudicial barriers. I won't dwell on them, because we all recognize them as being very effective deterrents to a good and easy flow of communications.

Whenever you say something, or whenever you exchange a thought or an idea, the purpose is to have something done, isn't it? The question then is: "Is it going to be done?"

So you have to have a system of checks and balances to see whether the understanding takes place. Many of us feel that if we've said something, or if we've written a directive of some kind, some sort of alchemy takes place and a man or a woman who has a limited intelligence quotient suddenly becomes a very perceptive person and gleans every nuance of meaning that we want to force into a written or oral communications item.

Don't work on that premise. Work on the premise that something is misunderstood very easily and has to be repeated.

How can you constantly check and balance your whole communications program to see whether your communications are effective? Look over your

present set-up, and make a sample survey of some kind, on any simple question, and see how effective it is. Try as many methods as you can to see whether you will strike upon a particular method that will be effective upon a particular occasion.

How can you generally improve your communications? I don't think there's a better way to do it than by meeting people face to face because when you meet people face to face and exchange thoughts and ideas, you speak with your lips, with your eyes, with your eyebrows, with your body. This vis-a-vis relationship is one that tells you what the listener hears, very quickly. No time lag or any prejudicial barriers exist between your saying something to this person and the person's doing something in response.

Whenever you talk to someone, try to find a common ground. I'm sure that any two people on any given occasion can find something in common to talk about. But it's your job to be aggressive in this effort.

Use simple and familiar terms. If there is misunderstanding of the simple words, you see how the problem is confounded when you get into very large and very obscure terms.

Build up your communications, whatever they are, from familiar situations. In other words, they should not be artificial and forced. They should be related to the job situation, and should generate automatically and naturally from the particular situation.

Throughout any program of communications you must add the most important thread of sincerity, because there is something about that particular item that communicates the most loudly of them all.

Building a Productive Work Climate

By Earl G. Planty, Ph.D.*

• Henry Kaiser got together all of his supervisors in a giant amphitheater for a three-day conference last year. One day, after the discussion had been going for quite a long while, he said: "Could I ask this group of people a question?"

He asked: "What in your opinion is the greatest influence for good in this society today? "What's making it rich and wholesome and fine? What's strengthening America and our people? What's rewarding us?"

"And on the other hand: What's eating away at us? And frustrating us? And annoying us, and sickening us?"

The supervisors said: The church; the Four Freedoms; the initiative and power of our people; our natural resources, the trust. They mentioned many things on the strong side, and some on the weak side—debt, and big government, and indifference; threats from abroad; overemphasis on technology, and a dozen other things.

One man said, "The schools don't teach children to spell any more. They can't add, and they're indifferent. I don't think the schools are an influence for good; they're an influence for the opposite."

None of them gave him what he was after. What do you think Mr. Kaiser believes is the greatest influence in our society today?

He thinks supervisors are — operating room supervisors, and the thousand other supervisors and managers that he had in his giant group. Why are they so important?

To the man who said: "The school is influencing my kids," Mr. Kaiser said: "How many hours a day do you send your kids to school?" The man said, "Five."

Mr. Kaiser said, "I know you're vice-president of the engineering firm, and you have five men reporting to you. How many hours a day do they come under your guidance and direction?"

The fellow said: "Seven and a half hours a day." Mr. Kaiser continued, "How long are you going to send your kids to school?" The man said: "I hope they earn their living when they're 20 or 22."

"How long are these people going to come under your influence in your department?" Mr Kaiser asked. The man answered: "If I'm on the payroll and we're still in business, and they're living and doing right—I guess until they're 65."

Every working day of our lives, Mr. Kaiser went on, 65,000,000 of us walk into some hospital, office, hotel, industry, or school, in which a dean, or a president, or an administrator, or a supervisor of nurses, or an operating room nurse supervisor presides and builds climate; builds an environment: a work relationship, that lifts and inspires and enriches and satisfies — or, on the

(Continued on next page)

*Dr. Planty is professor of management, University of Illinois, Urbana.

other hand, that frustrates, and annoys and irritates and eats away at us.

Mr. Kaiser describes the job of every president and every vice-president, every foreman and supervisor, *everybody* who manages people, as leadership. How many leaders are there—bosses, managers, foremen, superintendents, department heads? There are eight and a half million in this profession—eight and a half million that are guiding and directing and influencing other people one way or another.

Mr. Kaiser describes leadership as building climates in which people realize the best that's in them. He says—and the psychologists and the doctors support him—that no one of us is working very near his top potential. He draws a line up here and says: "Let this be your potential, what you could do—the number of new ideas you could contribute in a day; the number of details you could handle in a day; the amount of inspiration you could give to others working for you; the service you could render to the community and to your employer and to public relations. How close to this, if it's 100 percent, are you working?"

I've asked my graduate classes at the University of Illinois what percentage of their potential they performed at during a given week. I have never got an average of above 60 percent. I've worked with many businessmen. I've never had an average above 85 percent, even with presidents and vice-presidents.

Mr. Kaiser says it's the job of everyone in leadership to bridge this gap between performance—what our people really do—and potential—what they could do.

Henry Ford says leadership can make the difference—perhaps 10, 8, 6, or 30 percent—between what a man properly motivated, eager to let go will do, and what one either not motivated, ignored, or frustrated and annoyed will do.

I'm an amateur gardener; I've grown prize chrysanthemums. Chrysanthemums don't grow well in the shade; they don't grow well where it's cold and damp and sour and inhospitable. People don't either.

How is it in your department? Did you ever look upon yourself as a builder of a climate—one that's warm and rich and full of tender care and attention in which people could grow? This is what Henry Kaiser says is your responsibility.

The president of General Electric recently wrote in his book, *New Frontiers for Professional Management,* that his company's research into human relations indicates that the growth or lack of growth of strong leaders and self-reliant individuals depends to a great deal upon "climate." He says this tone or atmosphere can be subjected to analysis and to a certain degree of measurement—and that the superior and the individuals in the company can do specific things to improve the climate so that the men will develop faster, and work will be done more effectively, more enthusiastically, and more co-operatively.

How do you build climates? How do you motivate? This is like asking: Tell me how to practice law in five minutes, or, how to practice medicine in 10 minutes.

However, here are six simple items to consider:

1. People grow, and reach, and perform, and enjoy satisfaction when they know what they're supposed to do—when they know what their job is.

How long has it been since you sat down with your nurses and went over the job description, and asked them, "How would you tell me, Helen, or Mary, what you conceive this job to be?" Perhaps you have a written description that was given her five years ago when she came in. Maybe you don't even have that. But you've cleared exactly what it is she should do. Then you sit down and go over it. Make sure that you're tuned in together, on exactly what the work responsibilities are.

People perform well in climates in which they know what they are to do. There is nothing more frustrating than to wonder whether this is your job or somebody else's job; or to be enthusiastic and able and reach for it, and still have a guilty feeling, wondering whether you're taking something that somebody else should take.

2. People do well when they know HOW to do things. Are they confident, are they assured? Are you certain you're not asking one of these girls to do something that she is afraid she can't do; that she withdraws from; that she may have failed in doing? Have you taught her carefully, step by step, and observed her performance, and given her some practice, and then turned her on her own to perform?

Are you sure that this girl has been trained? And that's your responsibility as a leader—to train her.

Are you sure that she can do these things that she might be avoiding or might not be doing very well? If she can't—you're the boss! You're paid to get work from other people! It's not her fault that she's not doing it—it's the leader's.

3. Does this person have full authority and responsibility for what he's supposed to do? Can he order the supplies? Can he close this or that department? Can he make demands on others for time or assistance or money?

Does he *know* what his authority is? Is this clearly spelled out and talked over and reviewed?

How often do you have to review it? Surely every year, because these things change; people forget.

If I'm aggressive and reaching and grasping, and you give me a certain amount of authority this year, in about six months I build it up to so much more, and you have to get me back in line or promote me to where I can handle that much authority.

4. Are your personnel paid adequately? Is your pay comparable with the prevailing community pay scale and with that of other hospitals in the neighborhood? Pay is one way of recognizing and rewarding. You can't expect services from substandard rewards.

5. Do the people have a voice in making decisions affecting them? If something has to be done, how often do you call them in and ask them what they think about it—what they suggest?

Researchers from the University of Michigan found that when clerical workers exercised the authority to make group decisions in relation to their jobs, their satisfaction with their work, with their superiors, and with each other all improved significantly. Their feelings of self-realization increased, and their production rose by 20 percent.

Study after study shows that these results come when you have time to let people have a voice in their own decisions.

6. People, to be motivated, to let themselves really go; to realize their full potential; to be amenable to your suggestions; to take leadership—must feel they are part of things; must feel that they belong. This is a basic human need.

All of us want to be "wanted." We want to be needed; we want to be part of things. Those who "belong" will do tremendous things toward breaking this gap down. And how do they get to "belong?" By being invited in, by being wanted.

Ask yourself, "Do these people who report to me know that I'm glad to have them? Do they know that they are helping me, and that I assume responsibility for their growth, and their pay, and their work tools and equipment? And that in effect I rather like having them around here? Or, do they have to guess about this?"

I used to have a title: "Executive counselor." I wish I could tell you the presidents who used to come to me and say: "You know, I don't know what this board chairman thinks about me."

Imagine, at this level, worrying whether they're wanted! Then what do you think the little people do? And when they are wanted, the way they respond is something tremendous!

Franklin D. Roosevelt had a knowledge of this "belonging" and its value. He got up on the radio in bad times, low morale, confusion, and he started talking. He said he was talking to "the forgotten man." This turned out to be about 20,000,000 people who were forgotten by Washington—people nobody in Washington had ever talked to.

People around the country were talking about Mr. Roosevelt. They felt they knew him personally. He was talking to the forgotten man, and they thought THEY were forgotten! He made a "new deal" to which they belonged.

He MUST have made SOME mistake, mustn't he? But no Democrat has ever admitted that!

Do you want this kind of support in your divisions and departments? Then you must study the proper climate in which people reach out and grow.

Discussion Period

Q. In spite of all my efforts to have good communications to other departments in the hospital, I have difficulty in getting them to follow certain standards for prepping patients. Have you any suggestions?

MR. KOWALCZYK: In the first place, what is the significance of these "standards?" What do they mean exactly? How are they evolved?

If the standards are significant, then I think what you should do, is:

—Try to repeat them as often as you can.

—Try to get people who are going to be affected in following these standard patterns to participate in some way in either the revision or the genesis of these standards.

—Review the standards frequently, quite often in fact.

—Check as to whether or not they're followed.

In other words, the general principle here is that people just don't like to follow something just because it's written down, or because we say it's "standards." They want to know why. It's your job in most cases to "sell" the significance of and the need for these standards. When the persons understand these, their psychological approach will be much better.

DR. PLANTY: I would do all that Mr. Kowalczyk says, and then the first time there's a violation I'd talk with the individual about it.

The second time there's a violation, I might talk with the individual again, very promptly. The third time, I'd take it up with my superior.

Q. In interviewing a nurse for a staff position, how can I best get information from her which will help me find out what her capabilities are?

MR. KOWALCZYK: When you're interviewing someone for any particular position, you must have thought through this position. You must

(Continued on next page)

ask yourself: "What qualifications are needed or wanted in this particular job?" Communications become very difficult and very frustrating when you don't get what you don't know you want in the first place!

This analysis calls for a good definitive review of the job itself. You should list the technical needs, the psychological needs, the social rapports, and so forth that you want in a particular job. Then start the questioning.

DR. PLANTY: I agree. Find out what you want! Do you want a person of average intelligence, or above average intelligence? How much above average intelligence? Find out what grades she's had in school; there is some relation to intelligence. Find out what scholarship awards she has had, or hasn't had; they have some relation to intelligence.

Find out what she's reading; what television programs she watches; set up some questions that in your opinion would reveal intelligence. Give her a problem or two, and judge her intelligence. But prepare yourself for these questions before your interview.

Maybe you're interested in her drive; how much energy she has. You ask her, "What did you do in school?" She studied. That's one thing. But if she studied and worked a little while she was doing it, that's something more. If she studied and served on the Student Council and acted in a hospital play, this is more.

Does she have energy enough to do a variety of things? If she has, maybe this will carry over into the job. By asking planned questions you may draw from her these things.

Above all, however, you have to establish a rapport before she'll let go and tell you these things. In industry one custom is to take folks to lunch and sit down as casually and informally as possible, and try to get the barriers down.

This individual has come to you to get a job. She's a fool if she isn't trying to hide some of her weaknesses. Your job is to get her to be herself; to act right here in this situation the way she will act in your hospital. She'll do this if you disarm her—if you get her out of the rigid office and talk informally and in a very friendly fashion.

You have to know what you want; put her at ease. Above all, let her talk. You just ask a few questions and sit back. Don't be afraid of silences. Long silences may reveal some important things about people.

THOMAS FREESTON, vice-president, personnel, Ethicon Inc., Somerville, N. J.: I'd like to add two other concepts in this matter of interviewing:

1. If you think wholly in terms of selection from the standpoint of interviewing, you're going to be losing, or misusing, or not applying all the tools available to you.

Selection is a process of using every available tool that you can get your hands on: tests, reference checks, credit checks—any tools that you can utilize, use them.

2. The second concept is that to predict how people are going to act in the future, study their past behavior.

If you're interviewing an applicant, and you find as you talk with that person that his whole work experience is one of failure—you don't want him. So look at his experience. Start judging how successful he has been, in whatever job he has had, and work from that premise.

In the interview itself, look for little clues to give you indications of this person's personality, and his strengths and weaknesses. You're not going to pick up these clues quickly; you're going to learn how to see them. Reading books on the interviewing process will help you.

MR. KOWALCZYK: The atmosphere you create is one that comes back to you. If you're going to emphasize the technical aspects of your job, the applicant thinks that this is what you want. Many times you overdirect the interview and get the responses that you want instead of hearing what this person has to say.

EDITOR'S NOTE: Space limitations prevented our including here all the questions and answers from this discussion. However, because the subject matter is so timely and the advice of the speakers so helpful, we will present the concluding portion of the discussion in the July issue.

AORN Board Member Dies Suddenly

Mrs. Evelyn Ellsworth, R.N., member of the board of directors of the national Association of Operating Room Nurses, died suddenly at her home in Elgin, Ill., on April 14.

Mrs. Ellsworth was first president of Unit I, Massachusetts Association of Operating Room Nurses. She served as co-chairman of the program committee for the third national conference of the AORN in Boston in 1956. She took an active part in promotion of formation of a national organization. When the national AORN was established in Los Angeles, in 1957, she was elected to a two-year term on the board of directors.

Until Mrs. Ellsworth moved to Chicago, a little more than a year ago, she was for many years operating room supervisor, New England Hospital, Boston.

SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Suggestions will be welcomed for subjects to be covered in future issues.—The EDITORS.

Dettinger, Garth B., and Bowers, W. F.: "Tissue Response to Orlon and Dacron Sutures. A Comparison with Nylon, Cotton and Silk." *Surgery* 42:325, August, 1957.

The ideal suture material will keep a wound approximated until it is healed enough so that dehiscence is no longer a possibility. The authors evaluate the many factors which contribute to the efficiency and safety of suture material.

Cotton and silk are available at low cost. Catgut costs much more, but has a higher tensile strength and is a finer suture. Nylon has 30 percent more strength than silk; orlon and dacron about the same.

Suture materials are variously affected by wetting, which is inevitable in any surgical event. Nylon loses about 15 per cent less tensile strength when wet than silk; orlon about five percent. Dacron is unaltered in the wet state. Cotton *gains* about 10 to 30 percent tensile strength when wet.

Chromic catgut is the strongest suture material size for size in the dry state. It loses about 30 percent of its tensile strength after four days in tissue, and 50 percent in seven days. Plain catgut loses about 90 percent of its strength after six days' implantation in tissue.

The tensile strength of synthetic fibers *in vivo* was not measured, but other experiments reveal them to be superior to natural fibers in resistance to weak alkalis and weak acids.

Other necessary features of suture materials include the ability to be sterilized, non-capillarity to prevent the accumulation of serum or other fluids conducive to bacterial growth, and a resistance to bacteria. Silk, cotton, orlon, and dacron all withstand exposure to heat. The synthetics undergo little swelling when moistened; hence, they have a low capillarity which minimizes collections of bacteria media and also prevents the tissue compression which results from increased suture volume after implantation. The synthetics do not deteriorate in the presence of bacteria or fungi.

Good suture material should be pliable and resilient to make for ease of handling and secure knot-tying. There should be no sharp or pointed surfaces. The synthetic fibers were found to be pliable and to have the feel of cotton and silk. The stretch of dacron is comparable to that of silk; the stretch of orlon, to that of cotton.

Natural fibers are known to be noncarcinogenic in human tissues. Although the work with synthetic fibers has been limited to *animal* experimentation, the history of their use in humans is sufficient to include them without reservation for future use.

Tissue reaction was studied by implanting sutures of comparable size in the subcutaneous tissue of 85 rats. Reaction was determined on the basis of polymorphonuclear leukocyte response, the width of tissue reaction and cellular density, the onset of significant fibroblastic activity, and the extent of edema. The synthetic fibers—orlon, dacron, and monofilament nylon—were less irritating than cotton or silk. Dacron appeared to be the least reactive.

Harrison, G. Kent, and Cruickshank, D. B.: "Prevention of Infection of Thoracic Surgical Wounds by Staphylococcus from the Patient's Skin." *Lancet* 1:288, Feb. 9, 1952.

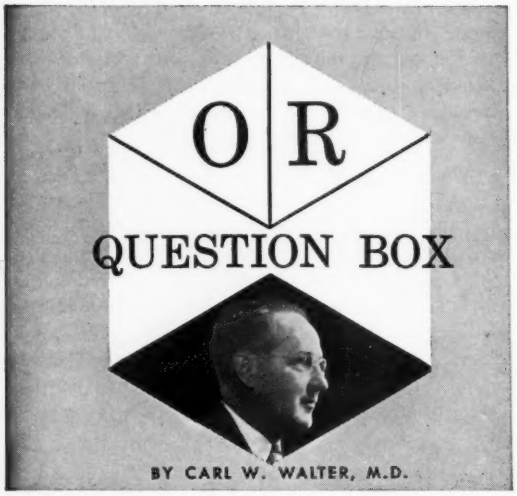
In one year, nine of 69 consecutive thoracoplasties were infected within seven days of surgery. The infection involved the suture line, the wound, or Semb's space. The bacteria were identified in 21 cases—16 *Staphylococcus aureus*, three *Staphylococcus albus*, one *Streptococcus viridans*, and one *Corynebacterium acnes*. In four cases, the infecting organism (identified by phage typing) was cultured from the wound edge.

Bacteriological surveys of other possible sources of contamination and phage typing identified the skin as the source of infection. Routine preoperative skin disinfection technic was changed to utilize one percent iodine in 78 percent ethyl alcohol. There was an immediate decrease in infection to 3.7 percent (16 in 433 consecutive cases).

The punctured glove as a factor in wound contamination was also evaluated in this study, but because the glove technic and skin disinfection technic were changed simultaneously, it was impossible to say which was responsible for the substantial reduction in wound infection. Cultures were made of surgeons' palms and fingers and the insides of surgeons' gloves immediately at the end of a case. In 47 instances, no post-scrub antiseptic had been used, and 76 percent of the cultures were positive—36 percent for coagulase-positive staphylococcus and 40 percent for a variety of other organisms.

In 81 cases, gloves were put on preoperatively after a finger dip in one percent iodine, and only 16 percent of these cultures were positive—3.7 percent for coagulase-positive staphylococcus and 12.3 percent for *Staphylococcus albus*.

It is interesting that the strains of staphylococci found in the gloves showed no relationship to those found in the infected postoperative wounds.



Assisted by Dorothy W. Errera, R.N.

Q. Should the surgeon wear a fresh mask for every case?

A. Masks are of such limited effectiveness that they must be changed every half hour to achieve even minimal protection. This is obviously not feasible during a long case, but the circulating nurse can change masks on the team members. Between cases, the surgeon should change his mask as surely as he changes his gown and gloves. Masks dropped from the face must not be used again, because the discharges trapped in the mask dry and entrain immediately when the mask is worn again.

Q. Is is necessary to sterilize masks between cases after laundering?

A. Sterilizing masks after laundering eliminates the occupational hazard of cross-contamination between users.

Q. We still cannot convince our surgeon he should cover his nose with his mask. Is this really necessary?

A. A mask worn over the mouth keeps the operator from spitting into the wound. Although contamination through the nose is slight unless air is forcefully expired, what surgeon has the respiratory integrity to get through a procedure without snorting, blowing, or expostulating?

Q. What do you think of the new idea of wearing two masks?

A. Two masks are worse than one. The mask is a filter—an averaging device—which traps droplets as they are expired and accumulates them in its meshes. As the droplets dry, droplet nuclei entrain in the air expired through the mask. Two adequate masks present such resistance to expired air that bacteria are deflected outward around the edges of the mask in streams of expired air, rather than being trapped as air passes through the mask.

Q. Is there any value to a wet mask? It is terribly uncomfortable to wear.

A. Wet material is a poor filter. Bacteria will merely pass out around the edges of a wet mask.

Q. Please express your views concerning an unmasked patient in a sterile draped operating room. Frequently this comment is made: "Why should we mask if the patient is unmasked?" The patient can't be masked during intubation.

A. The organisms from the nasopharynx of the patient may be as dangerous as any in the operating room. Hence, during a procedure under local anesthesia, the patient is masked.

When inhalation analgesia or anesthesia is used, the organisms in the patient's expired air are confined to the anesthesia apparatus. The organisms freed into the air during the few minutes needed for intubating the patient are of no substantial significance if proper barriers are erected about the surgical field.

Q. When we use the floor disinfection method you describe—that is, flooding and wet-vacuum pickup —must the solution remain on the floor any particular length of time?

A. By the time 10 liters of solution are spread over the floor and any one area is cleaned up, there has been exposure for at least three minutes, which is sufficient for the job.

Q. Should we air our operating-room mattresses routinely as the wards do?

A. Airing mattresses and bedding satisfies the housewifely urge and makes them smell better. This concept of sanitation crept in years ago. Except for the oblique benefits obtained from exposing the usual pallet of splotch and stain to view, such energy is better directed. The staphylococcus lives for several weeks on a mattress. The tubercle bacillus survives for several years in dried sputum.

Q. We are considering the use of ultraviolet to control our infection problem. Do you approve?

A. Ultraviolet radiation has a surface effect only. Bacteria which are hit directly by ultraviolet rays are destroyed, but bacteria protected in dirt, in the shadows of dirt, or in droplets are not affected.

Q. How can nurses tell the medical staff about sepsis and good technics without antagonizing the staff?

A. Ask questions to start discussion. Don't phrase the question so pointedly it provokes defensive thought, but rather ask for information that you believe will prompt discussion. Also, culture supplies, masks, floors, bedding, and air to demonstrate the need for reconsideration of aseptic technics. The most haughty individual can be humbled by a revealing culture; co-operation, self-compelled, usually results.

What every O.R. Nurse should know about A·S·R STERISHARP blades

Q. *What is a SteriSharp?*

A. It is a sterile-packed surgical blade made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments it will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharp blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharp packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharp packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharp blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharp blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharp does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HT
380 MADISON AVENUE, NEW YORK 17, N. Y.

Literature and samples for your evaluation are available upon request. And if you have further questions—ask us.

A·S·R precision products

SteriSharps . . . the first and only sterile, stainless-steel surgical blade

• *Time limitations made it impossible to answer all audience questions submitted during sessions of the fifth national congress of the Association of Operating Room Nurses in Philadephia. To answer some of these queries and make the information available also to nurses who were unable to attend the congress, we have invited several program participants to give their opinions in this column.*

This month's "guest expert" is Sister Mary Albina, O.R.S., St. Agnes Hospital, Philadelphia.

Q. Should there be rotation of scrub nurses to all surgical services? If so, how should this be arranged?

A. Yes, scrub nurses as well as competent scrub technicians should be rotated to all types of surgery. This practice prevents increased tension and frustration when the unforseen eye, chest, or brain injury and other emergencies arise. Personnel should be rotated gradually from minor to major surgery and finally to the specialties.

Individual native ability, skill, capabilities, and understanding of the procedures should be taken into consideration.

Q. How do you suggest overcoming the supervisor who resents outside suggestions and puts into use only her own ideas?

A. Perhaps the best results could be obtained by making the supervisor a member of a committee in which objectives and aims are stressed. If we would like to function as an efficient team for better patient care, we must be willing to pool knowledge, share ideas and experiences with others, and accept suggestions from others if they help to reach our goal of "total patient care."

Q. What can you do with doctors who belittle your technic on dirty cases, saying, "Oh, it's not necessary to take such precautions?"

A. Terminal sterilization and cleaning of the room after a dirty case are fundametal principles of aseptic technic and must be carried out effectively, for the protection of the patient and personnel. Studies and research have pointed out that strict adherence to these principles is necessary to prevent further infection.

The chairman of a functioning "infection committee" could be of great value in eradicating laxity in asepsis among surgeons.

O. How do you suggest handling the surgeon who when told he has broken technic completely ignores the notification or refuses to do anything about it?

A. If a private conference does not improve his attitude and the correction is justified, the chief of surgery should be informed and asked whether he will observe the offender's technic. He will most likely handle the problem very effectively.

Q. Do you discourage surgeons from bringing their own scrub nurses?

A. A private scrub nurse can be very valuable if she is willing to follow the operating-room policies and share her knowledge, skill, and experience with students who are assigned to the patient.

Q. Should operating room nurses be asked to mix solutions to be given by the anesthetist, such as Surital or Pentothal?

A. Mixing anesthesia drugs I believe should be the sole responsibility of the qualified anesthetist. He or she has spent a year, at least, in learning the importance of proper dosage and effect of anesthetic drugs. The operating-room nurse is not prepared to take the responsibility of the anesthetist.

Q. Shou'd surgery be scheduled outside the operating room department?

A. For the protection of the patient and service to the surgeon, all surgical procedures should be performed where asepsis can best be carried out and all are concerned and informed with sterility and good technic. The operating room was designed by the architect for one purpose only — namely, surgery.

If this question refers to the booking of operations, the answer would be that scheduling should be done by the operating-room supervisor, in co-operation with the anesthesia department.

Q. Do you have routine fire inspection by a city fireman in your operating room? Who is responsible for teaching a fire drill or use of fire apparatus in the operating room?

A. The fire marshal periodically appears without warning for inspection. Operating-room personnel are made familiar with fire hose and apparatus during their orientation period. The operating-room supervisor must constantly remind personnel of fire hazards and is responsible for telling the team members the proper procedure, should such an emergency arise.

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The civil defense committee and the maintenance department, under the supervision of the city fire department, are responsible for fire drills.

Q. Should shaving of the patient be done in the operating room?

A. Preferably shaving should be done in the department. (EDITOR'S NOTE: Ideally, the skin is scrubbed four to five days preoperatively with G-11 or TMTD soap or detergent.)

The shave is *ideally* done in the O.R. by a skillful nurse or orderly, with good light, good position, and a razor which has been sterilized. A shave done inexpertly a period before surgery allows bacteria to grow in nicks and cuts and within the angry, red, infected skin through which the incision is made.

See "Preoperative Skin Preparation," by Carl W. Walter, M.D., in the September, 1955, HOSPITAL TOPICS, pages 74-79.

Q. If the schedule is short in the operating room, should O.R. nurses be sent to the wards?

A. No. A short schedule in the operating room is most welcome. It provides time that can be effectively used for inservice education activities and for group and individual conferences with the operating-room staff. The supervisor should have a well-planned program so that no time is wasted.

The fact that contact on the wards with infection and disease might result in the O.R. nurse's picking up pathogenic organisms on her clothing, shoes, skin, and in her nasopharynx, and then bringing them into the O.R. is another good reason for not sending O.R. nurses to the wards.

Q. Do you have any suggestions to combat apathy among transient staff personnel?

A. Apathy often results from lack of development of the concepts of the professional aspects and status of nursing and of the individual nurse. Every assistance should be given to the individual to help her find herself and become an active, interested member of the team. If, after a fair trial, her attitude has not improved, she should be removed to another department.

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Registrants at the Richmond institute. Mrs. Errera is shown second from left, Dr. Walter at upper right.

Dr. Walter Marks 20 Years Teaching O.R. Nurses

• Twenty years of teaching operating room nurses was marked by Carl W. Walter, M.D., at an institute for operating room nurses held in April at the Medical College of Virginia, Richmond. Dr. Walter is associate clinical professor of surgery, Harvard Medical School, and surgeon, Peter Bent Brigham Hospital, Boston.

Dr. Walter first began instructing operating room nurses at evening classes in Boston in 1938. He now conducts two institutes each year, throughout the country, with the assistance of Mrs. Dorothy W. Errera, R.N.

In Richmond, Dr. Walter warned that the operating room nurse, in order to survive, must lift her sights from the "rag-folding" of years past to the present demands and complexities of operating-room management.

This means, he pointed out, discarding a resistance to knowledge of budgetary matters, costing technics, and other administrative functions, and acquiring a working knowledge of allied fields as they affect her department.

Above: Military nurses attending the institute included (l. to r.): Lt. Leona L. Erdt, O.R. head nurse, and Lt. Ann Boyle Shutt, O.R.S., both of U. S. Naval Hospital, Portsmouth, Va.; Capt. Anne Showalter, assistant O.R.S., Maxwell U. S. AFB Hospital, Montgomery, Ala., and Capt. Rita J. Ball, O.R.S., Patrick U. S. AFB Hospital, Cocoa, Fla.

Center: Some of the equipment used in demonstrations at the institute is being inspected by (l. to r.): Veronica R. Marks, R.N., New York State Health Department, Albany; Mary Cibula, O.R.S., and Dorothy Brown, O.R. head nurse, both of Medical College of Virginia Hospital, Richmond; and Madeleine Y. Phaneuf, R.N., New York State Health Department, Albany.

Below: Participating in the institute was Peter Brand, research assistant to Dr. Walter, shown here with a group of exchange students at Maryland General Hospital, Baltimore. Ligaya Dagdayan (l.) and Pat Padre (r.) are from the Philippine Islands, and Eunice Ree is from South Africa.

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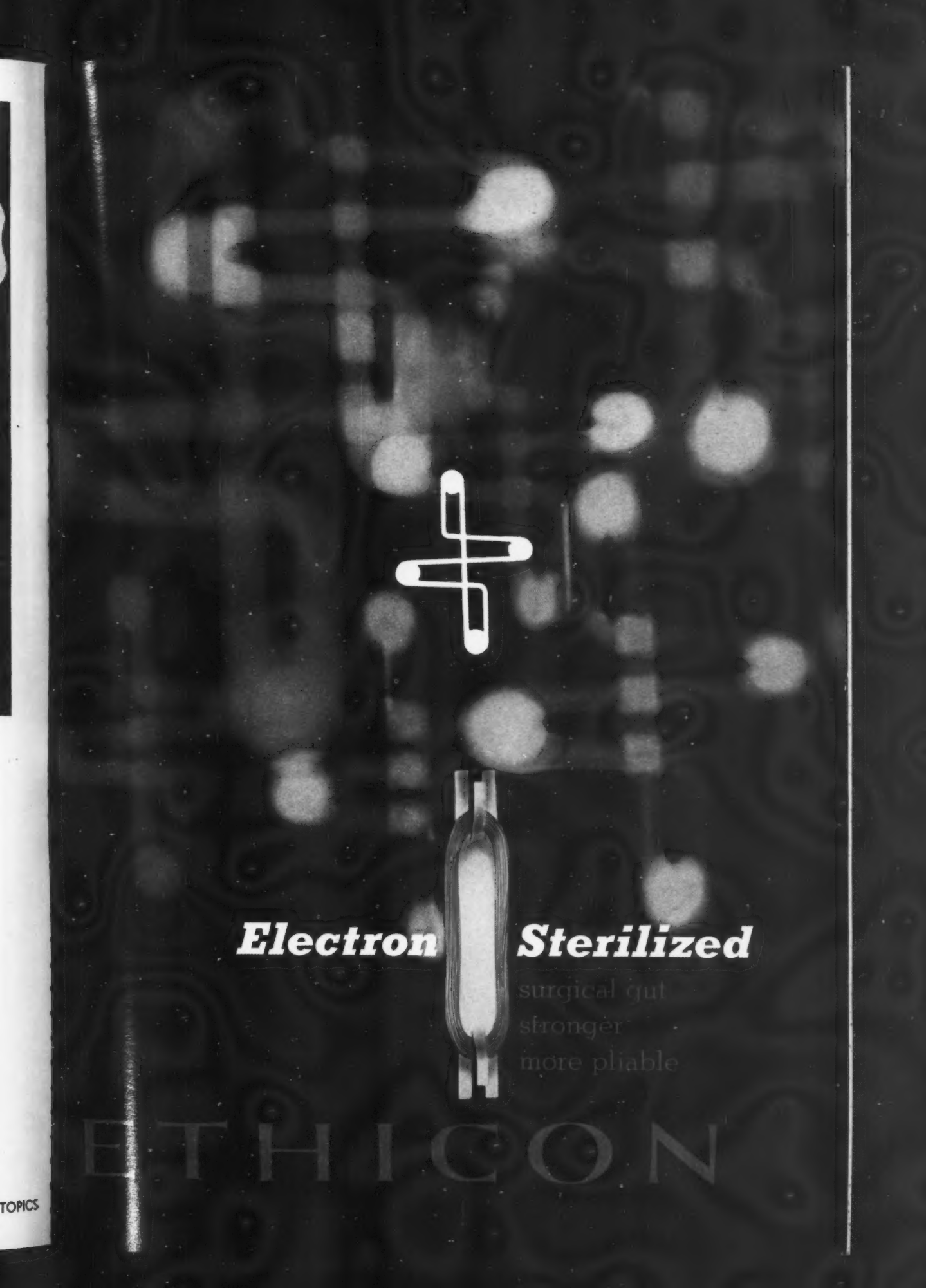
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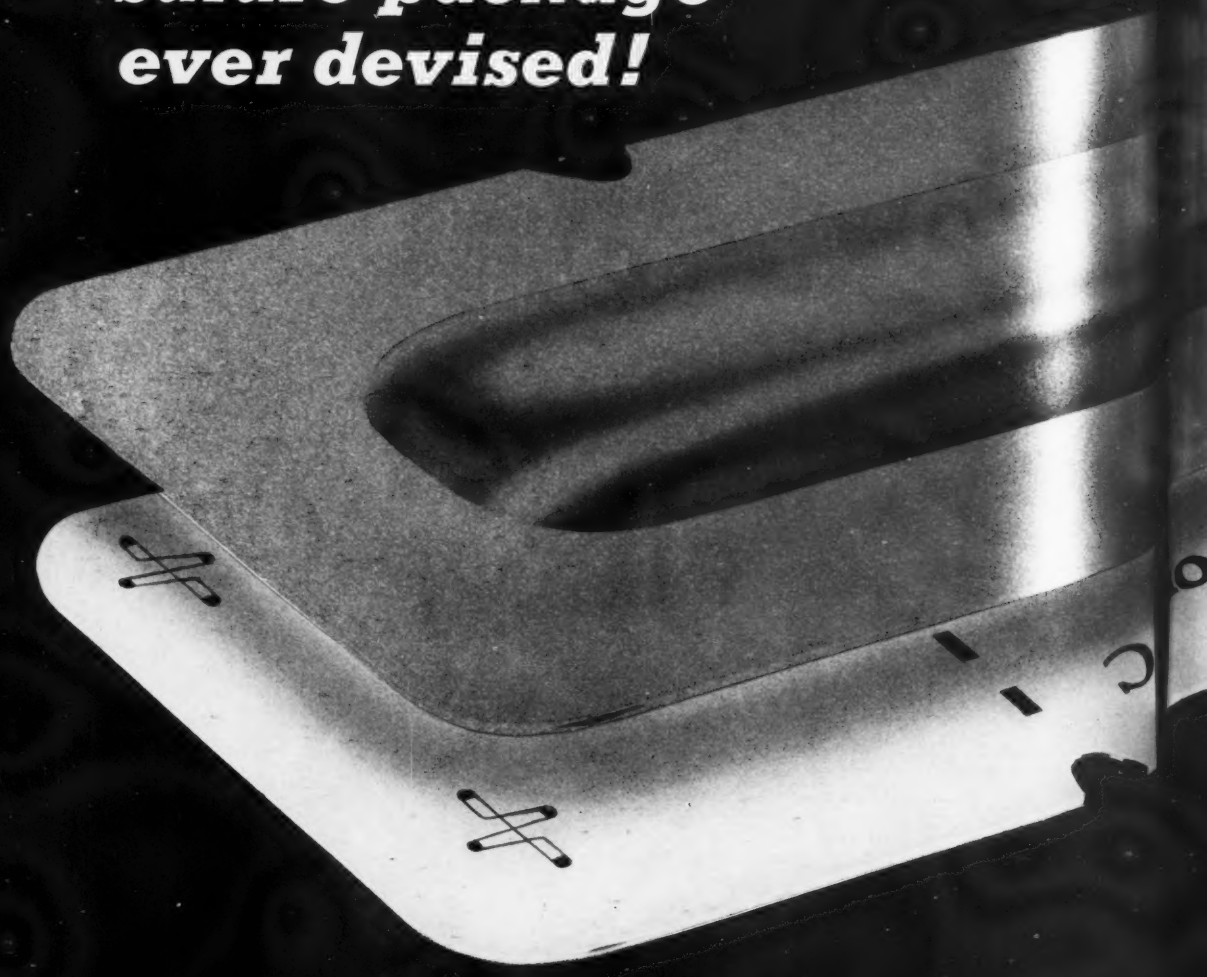

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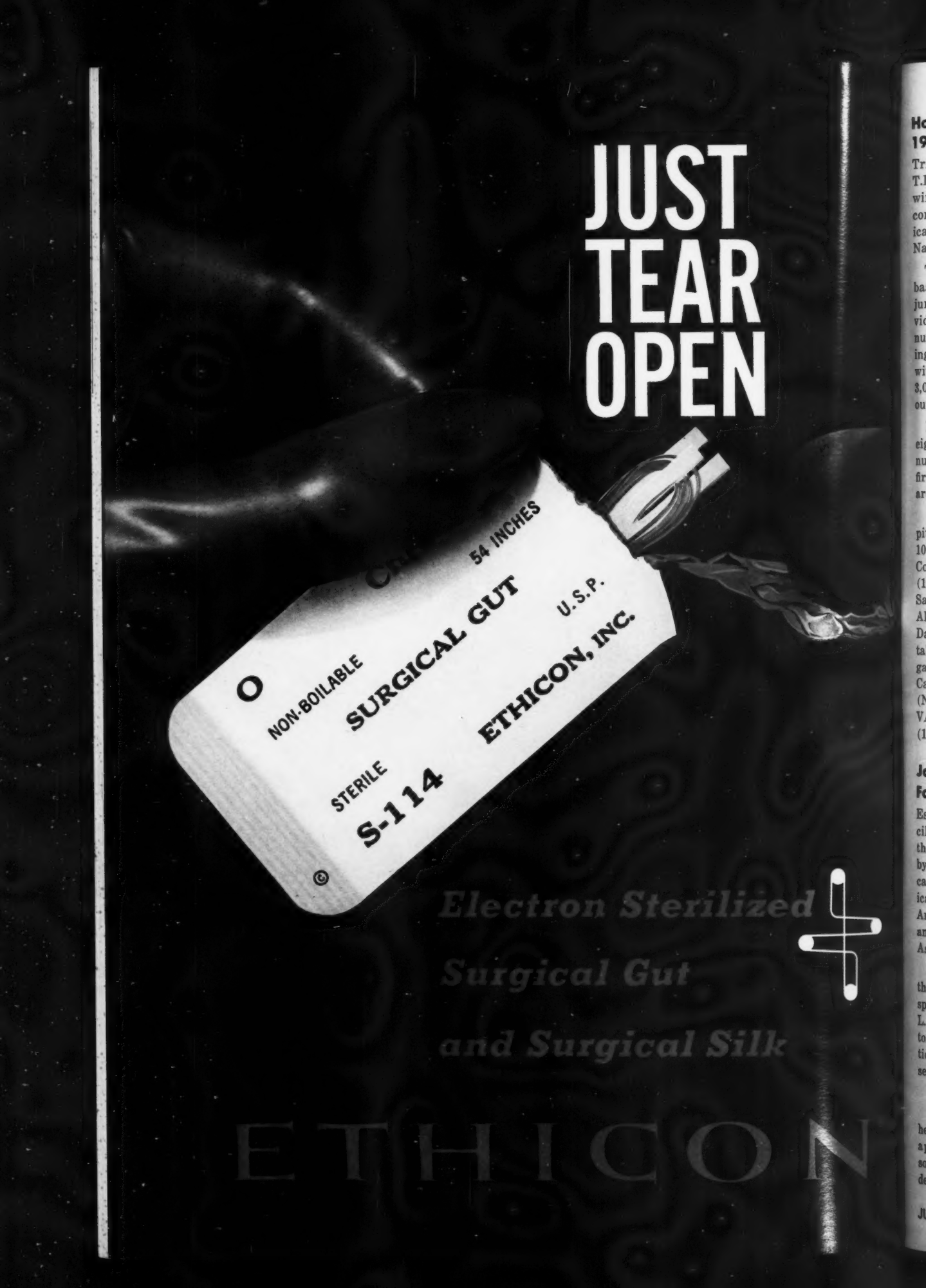
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Honolulu Hospital Wins 1957 Safety Award

Tripler Army Hospital, Honolulu, T.H., has been named grand award winner of the 1957 hospital safety contest, cosponsored by the American Hospital Association and the National Safety Council.

The contest was judged on the basis of the lowest number of injuries among employees of individual hospitals in relation to the number of man-hours worked during the year. Tripler Hospital, with 1,700 employees, operated 3,057,067 man-hours in 1957 without a reportable injury.

Hospitals were divided into eight groups according to the number of employees. Winners of first-place plaques in each group are:

Central Oregon District Hospital, Redmond, Ore. (less than 100 employees); T. J. Samson Community Hospital, Glasgow, Ky. (100-199); Brookside Hospital, San Pablo, Calif. (200-299); St. Alexius Hospital, Bismarck, N. Dak. (300-449); U.S. PHS Hospital, San Francisco (450-599); Gorgas Hospital, Balboa Heights, Canal Zone (600-799); Brooklyn (N.Y.) Hospital (800-999); and VA Hospital, Northport, N.Y. (1,000 or more employees).

Joint Council Formed For Health Care of Aged

Establishment of the Joint Council to Improve the Health Care of the Aged was announced recently by four organizations, the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association.

The council will be made up of three representatives of each sponsoring organization. Edwin L. Crosby, M.D., executive director, American Hospital Association, has been named interim secretary of the group.

Objectives of the council are:

1. To identify and analyze the health needs of the aged; 2. to appraise available health resources for the aged; and 3. to develop programs to foster the best possible health care for the aged regardless of their economic status.

Studies already underway by the participating organizations will be coordinated through the council. Research will be intensified, and projects will be activated as rapidly as possible.

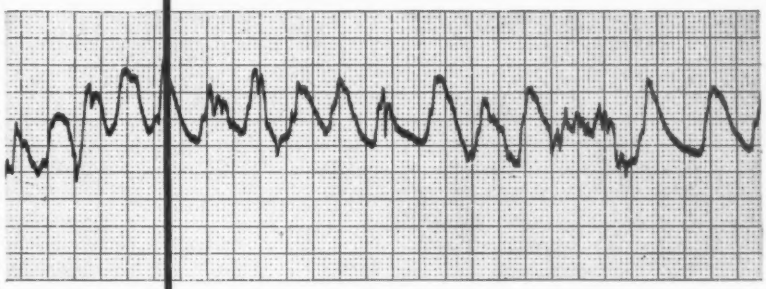
According to a council announcement, one of its principal immediate projects will be development of programs and facilities tailored to the health needs and finances of the aged. The council also plans to work with health insurance groups in an effort to improve coverage of the aged. In addition, an attempt will be made to stimulate activities to help older people at the state and community levels of government.

Columbia Medical Dean To Retire in June

Columbia University, New York City, has announced the retirement, in June, of Willard C. Rappleye, M.D., dean of the Faculty of Medicine and College of Physicians and Surgeons since 1931, and vice-president for medical affairs since 1949.

Dr. Rappleye will be succeeded by Howard C. Taylor, Jr., M.D., professor and chairman, department of obstetrics and gynecology at Columbia since 1946.

Tragedy



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Birtcher Heartpacer (TM)
For external application in cases of cardiac and circulatory arrest to re-establish, through automatic electric surges, properly paced ventricular rhythm—for hours or days, as may be required. Indicated in many emergencies.

A collection of reprints from medical journals on the subject of cardiac arrest and resuscitation, including a cardiographic record of fibrillation, cardiac arrest and resuscitation will be sent on request.

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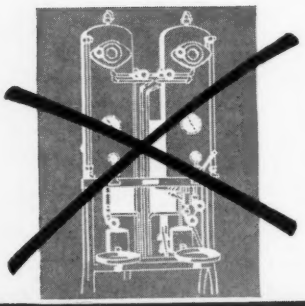

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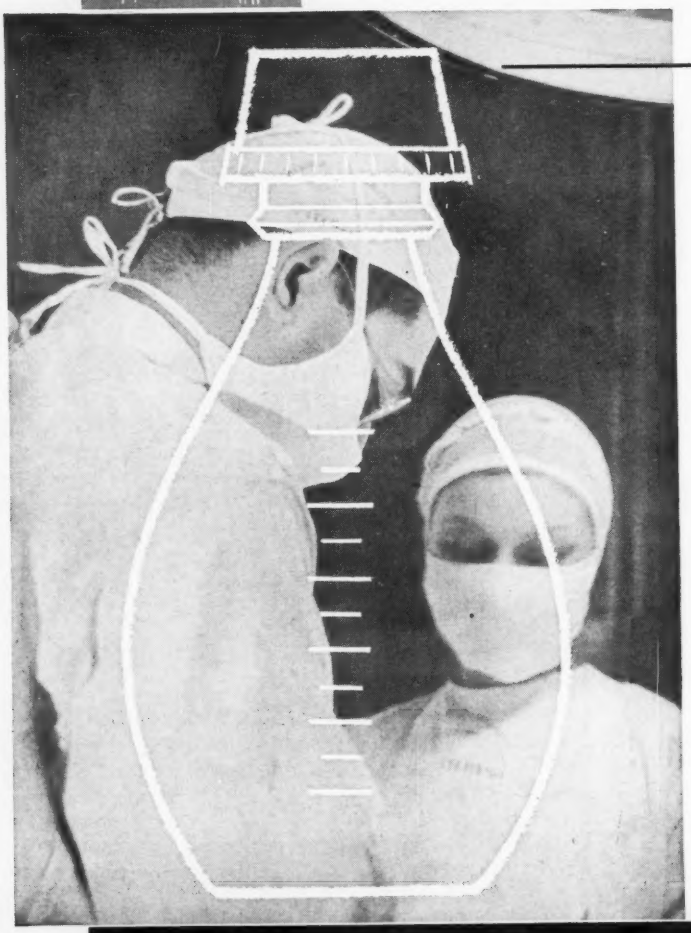

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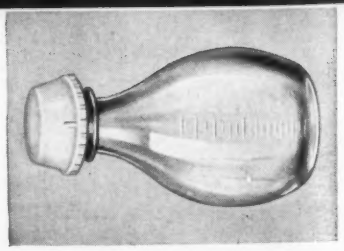

Study Finds Time, Money Saved With Disposable Units

By Carl I. Flath*

• A time and cost study comparing the present method of syringe and needle preparation and intramuscular administration procedure with a method utilizing disposable syringe units was undertaken by the nursing department at the Pontiac (Mich.) General Hospital, at the request of the director.

The study of administration procedure was carried out on the medical (62-bed) and surgical (61-bed) wards. The anticipated study was discussed well in advance of the actual time set for it, in head nurses' and supervisors' meetings and in the floor areas. The nurses were curious about the disposable units and were very willing to participate in the study.

A week was spent in the observation of each method. We conducted the study on the day shift, with our instructors acting as observers, and on the afternoon shift, with the graduate nurses timing themselves. Along with the reaction to the syringe, we were anxious to observe the nursing technic and patient's reaction.

PRESENT METHOD

At present our 2-cc. syringes and needles are sent to the floors in the same boat, in accordance with floor standards. There is always an adequate supply; deliveries are made three times daily.

Preparation, Injection, Cleanup:

Each floor was using a different method of preparation. The nurses on the second floor carried the boat into the patient's room. Fourth-floor nurses prepared the injections in the treatment room. After both methods were observed, an alternate method was recommended for use with the present reusable syringe and needle:

1. Check R_x card against Kardex.
2. Place card on tray.
3. Prepare R_x.
4. Draw up R_x in treatment room.
5. Lay on tray with alcohol sponge.
6. Go to bedside.
7. Identify patient.
8. Administer R_x.
9. Clean up tray.
10. Chart.

Note: Use alcohol sponge to wipe fingers between patients.

Because the procedure of preparing the medication at the bedside sometimes has an adverse effect on the patient, it was decided that the injections should be prepared in the treatment room.

Nurse and Patient Reactions:

Patients occasionally complained that the injection hurt.

The general complaint of floor nurses was that the needles plugged before the administration of the drug, and it was often necessary to change needles before injections. (This is the reason the second-floor nurses carried the medication to the bedside to prepare it.) The cleanup is done by an aide, who rinses the syringes and needles in preparation for their return to the central supply department.

DISPOSABLE SYSTEM

The following procedure for preparation and injection was used with disposable syringe† units:

1. Wash hands.
2. Assemble equipment.
3. Clean tops of vials with alcohol sponge; discard sponge.
4. Remove syringe, needle and needle-holder from packet; twist plunger in barrel to free it.
5. Remove clean alcohol sponge from container and place on table, clean side up.
6. Remove needle cover from syringe; place on clean alcohol sponge so as to keep open and uncontaminated. Check needle for tightness.
7. Fill syringe with air.
8. Insert needle in vial; force air from syringe into vial and withdraw proper amount of medication.
9. Remove needle from vial and pull plunger back until bubble of air enters the syringe.
10. Replace needle cover over needle, leaving plunger pulled back as above.
11. Put filled syringe on proper medication card.
12. Fill number of syringes needed; place on tray and wash hands.
13. Carry tray to bedside.
14. Identify patient and explain procedure.
15. Inject medication.
16. Replace needle cover and break syringe in two. Discard

(Continued on next page)

*Associate consultant, John G. Steinle and Associates, Garden City, N. Y.

†Stylex expendable hypodermic syringe—2 cc., Pharmaseal Laboratories, Glendale, Calif.

*Premier Haemo Digester

Ph. D* in the cleanser class

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Q. Does it really rinse free of deposits? **A.** YES, HAEMO-SOL softens water . . . keeps magnesium, calcium and cleanser in solution, OFF not ON, instruments and glassware.

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broken syringe and used needle in waste container on tray.

17. Cleanse hands with clean alcohol sponge between patients. Discard sponge each time.
18. Clean up tray.
19. Chart.

The nurses soon began using the plastic tips to cover the needles when carrying syringes to the bedside.

Nurse and Patient Reactions:

The patients made no particular comment.

The nurses' principle objection to the disposable syringe unit was that the needle was larger. They have been using #22 needles; the unit had a #20 needle. It was necessary to watch more closely for oozing at the site of injection. However, the consensus among nurses after they used the disposable syringe was that they much preferred it because the needle was always sharp.

The larger needle made it easier to draw heavy medications into the syringe. Although nurses would rather have a #21 needle, they prefer disposable syringes and needles to the old type, even with a #20 needle.

There was much favorable comment from the medical staff, many of whom expressed a desire to purchase the syringes for their own use.

NURSING SERVICE

Cost Study — Reusable Syringes

Areas studied:
Second floor—surgical
Fourth floor—medical

Time and Method:
5 successive days
7-3 shift—observer timed procedure
3-11 shift—nurse timed herself
Work sheets designating factors to be timed were provided.

	7-3	3-11	Remarks
Total number injections	144	146	
Average time preparing each injection	64.5 sec.	31.8 sec.	More interruptions on 7-3
Average time giving each injection	99.0 sec.	94.1 sec.	Dosage prepared in medicine room on 3-11
Disassembling syringe	13.2 sec.	13.2 sec.	3 syringes discarded
Total	176.7 sec.	139.1 sec.	

Over-all total

Total number injections	290	
Preparation time	51.5 sec.	—each injection
Giving injection	96.5 sec.	—each injection
Disassemble	13.2 sec.	—each injection
Total time	161.3 sec.	—each injection

Nurse's salary (1-year level—$2.11 per hr.) $.00058 per sec.
Differential $.000014 per sec.

Cost per injection $.00058 on all injections
plus $.000014 for 146 given on 3-11
Total cost $.0946831 per injection

Cost Study — CSR Processing

Unit of study—1 syringe and needle
(Processing unit—1 boat of 12 syringes and 13 needles)

Procedure:

1. Syringes and needles collected from each area by CSR personnel using carts.

2. Returned to CSR and sorted.
   (a) Needles soaked in detergent. Cleaned in needle-cleaning machine. Burrs removed. Booked on gauze squares for boats.
   (b) Syringes washed in syringe-washer. Assembled and put in boats.

3. Autoclaved.

4. Distributed to floors by CSR personnel as requisitioned and put away on floors in designated areas.

Collection and travel from CSR to floors and return	232.5	sec.
Sorting and cleaning	20.5	sec.
Packaging	16.57	sec.
Autoclave	21.8	sec.
Distribution	130.0	sec.
Total per unit	421.37	sec.

Average number processed per day—328 units

Worker's salary—$1.60 per hr. or $.00045 per sec.
Differential $.000014 per sec.

Cost of processing one unit $.00045 per sec. on all units
plus $.000014 for 164 done on 3-11 and 11-7 shifts

Total labor cost per unit $.19256609

REMARKS

1. Needles were cleaned by machine and all plugged needles set aside in CSR for further check and recleaning. Complaints or reasons for rejections on floors were that needles were not sharp or were plugged by medication after dosage was withdrawn. Clearing the needle of medication would eliminate the latter.

Thirteen needles were put in each boat; so one needle was always not used or rejected. This would amount to 15 in the 290 injections studied, or 5.2 percent. Discarded needles were counted in replacement figures used, or average of 3.07 percent.

2. Syringes were also washed by machine and rinsed in distilled water. They were rarely rejected because of sticking. Multifit syringes eliminated mismatching. Only three syringes were rejected in the 290 injections studied, or 1.04 percent. (This figure will vary from hospital to hospital, depending on the cleaning method used. At Pontiac General Hospital, the needles and syringes are machine-washed. The number of rejects is accordingly very low.)

Broken syringes were counted in replacement figure used, i.e., 66 per 10,000 syringes.

(Continued on next page)

This is the second in a series of cost studies on disposable vs. reusable syringe units. The first, which appeared in the Central Supply department in the April issue, was made at the D. C. General Hospital, Washington, D. C. —THE EDITORS.

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Cost of Supplies — Reusable Syringes

		Cost Per Unit
Needles—No. 22:		
Average number dispensed per month 7,025		
Replacement 216		
Each needle used 7,025/216 equals 33 times		
Purchase cost—$1.84 per doz. or $.153 each		
Cost per usage:	$.0046	
No. 24 Needles—cost per usage	.0052	
No. 21 Needles—cost per usage	.0046	
	$.0144	
Av. cost of 1 needle per usage $.0144/3	equals	$.0048
Syringes—2 cc.:		
Average number dispensed per month 10,000		
Average number replacements 66		
Each used 10,000/66 equals 151.5 or 152 times		
Purchase cost—$1.46 per each		
Cost per usage—$1.46/142	equals	.0096
Other materials:		
Gauze—Purchase cost $.009 each		
3 used in each boat of 12 injection units		
Cost per injection $.009 x 3/12	equals	.0023
Cleansers:		
Arex—Purchase cost 1 T. equals $.0291		
Use 6 gal. solution daily (1 T. to gal.) equals	$.1746	
Av. number units washed daily—328		
Cost per injection—$.1746/328	equals	.00053
Alcohol—Purchase cost—$.66 per gal.		
Daily use—1 gal.		
Cost per injection $.66/328	equals	.0020
Compressed air—$1.03 per day:		
Cost per injection—$1.03/328	equals	.0031
Ether—1 can per week		.006
Cotton—Cost $2.12 per 1,000—each $.0021		.0021
Steriltape—$.96 per roll—per unit $.96/328	equals	.003
Stone for removing burrs Distilled water Autoclave Boats	Estimate only	.005
TOTAL		$.03843

Cotton balls and alcohol used for skin cleansing on floors not included. Same amount for each method.

CENTRAL SUPPLY continued

CONCLUSIONS

1. There were savings in both time and cost when disposable syringes were used:
   - Time — 15.4 seconds per injection.
   - Cost — approximately 10 cents per injection.
2. The technic of administration was much better when the disposable syringes were used.
3. Patients made no particular comments with respect to either method.

Recommendations:

1. That disposable syringes and needles be used for the bulk of intramuscular injections:
   a. 2-cc. syringes with #24 needles or #25 hypodermic needles.
   b. 2-cc. syringes with #21 or #20 intramuscular needles.

NURSING SERVICE: Cost Study — Disposable Syringes

Same areas, times, and same method of study used.

	7-3	3-11	Remarks
Total number injections:	218	140	
Average time—preparation	68.6 sec.	47.1 sec.	All preparations done in medicine room
—giving injection	90.2 sec.	73.3 sec.	
—disassembly	2.6 sec.	1.3 sec.	
Total	161.4 sec.	121.7 sec.	

Over-all totals:

Number injections	358	
Preparation	60.2 seconds per injection	
Giving	83.6 seconds per injection	
Disassembly	2.1 seconds per injection	
Total	145.9 seconds per injection	
Labor cost per injection on floor		$.084629
Cost of syringe unit		.15 each

Number of disposable units used March 5-30, 1958, compared with usage of reusable units during a comparable period in 1957:

Reusable syringes	5,040	This, of course, merely indicates a trend and will need further check. It suggests about 5 percent of prepared reusable syringes never used.
Disposable	4,800	
Decrease	240	

COMPARISON OF STUDIES — Reusable and Disposable Syringes — Unit

1 injection or 1 syringe and 1 needle

	Reusable	Disposable	Remarks
FLOORS			
Average time taken to prepare one injection	51.5 sec.	60.2 sec.	1. New procedure established preparation of dosage in medicine room rather than at bedside. Increased preparation time but decreased giving time.
Average time taken to give one injection	96.6 sec.	83.6 sec.	
Average time taken to disassemble one unit	13.2 sec.	2.1 sec.	
Total time for one injection	161.3 sec.	145.9 sec.	Better technic—better effect on patient.
Labor cost	$.0946831	$.084629	Total time and cost decreased.
CSR PROCESSING			
Collection	232.5 sec.	NONE	Processing costs eliminated with disposable units. With an average of 9,000 reusable units dispensed monthly this would amount to about 1,050 hours per month saving.
Sorting and cleaning	20.5 sec.		
Packaging	16.57 sec.		
Autoclave	21.8 sec.		
Distribution	130.0 sec.		
Total time	421.37 sec.		
Labor cost	$.19256609		
SUPPLIES			
Syringes and needles—cost per usage	.0144	.15	Increased cost of supplies with disposable units.
Other materials—(Cleaning and autoclaving supplies)	.02403		
Supplies cost	.03843	.15	
TOTAL COST	$.32567919	$.234629	Total saving approximately $.10 per injection.

Administration Fraternity Honors Dr. Babcock

Alpha Delta Mu, professional fraternity for hospital administration students, presented an honorary membership to Kenneth Babcock, M.D., chairman, Joint Commission on Accreditation of Hospitals, during the fraternity's annual dinner, held in Chicago in conjunction with the Tri-State Hospital Assembly.

In accepting the membership, Dr. Babcock praised the growth of the fraternity which, he said, "is adding new status to one of the fastest growing professions in the country."

The fraternity, incorporated in 1951, is designed to broaden the scope of administrative experience for the student and to provide maintenance of professional contacts, continuing education, and research for those in the field.

The Alpha chapter of the fraternity is at Northwestern University, Chicago, and the Beta chapter, at Iowa State University, Iowa City.

Forty-eight students in the hospital administration program at Northwestern University were recently initiated. They are:

Allen, William J., Mandeville, La.; Arnwine, Don L., Oklahoma City, Okla.; Aronno, Robert J., Medford, Mass.; Baker, Capt. William, USAF, Rapid City, S. Dak.; Baylor, Robert B., Columbus, O.; Benson, William L., Springfield, Mo.; Biz, Robert, Strafford Spring, Conn.; Dorsett, James V., Jr., Birmingham, Ala.; Earle, Mrs. Selma, Chicago.

Faletra, Joseph L., Roslindale, Mass.; Frezza, Lt. John, USAF, Rochester, Pa.; Furlong, Louis H., Joplin, Mo.; Gibson, Leonard, Berkeley, Calif.; Gilmore, Robert F., Cleveland Heights, O.; Huesers, Robert E., Seattle, Wash.; Johnson, Rolin H., Minneapolis; Kohr, Roland E., Cincinnati, O.; Kasdan, Jerome M., Chicago; Krantz, Gerald M., Fairfield, Conn.

Malkin, Lawrence B., Chicago; Mariani, Peter R., Chicago; Macar, Dan, Chicago; Masar, Donald, Pueblo, Colo.; Meriwether, Richard E., Guthrie, Ky.; McGreevy, John C., Niagara Falls, N. Y.; Noakes, Walter B., Oklahoma City, Okla.; Norwood, John F., Raleigh, N. C.

Papaeconomou, Catherine, Tripolis, Greece; Parrish, Morris H., Nacogdoches, Tex.; Pasch, Capt. John E., USAF, Washington, D. C.; Puntenney, Frank, Jr., Wheelersburg, O.; Quittmeyer, Mrs. Dolores G., Chicago; Reich, Leo, Lansing, Mich.; Ruthrauff, James C., Overland Park, Kans.

Samuels, Jack L., Chicago; Saunders, Joseph A., Berkeley, Calif.; Shepherd, James F., Iowa City; Shirtz, Thomas, Brooklyn, N. Y.; Stellner, John L., Rochester, Minn.; Stickney, David, Chicago; Streit, Thomas J., Chicago.

Tittle, Robert A., Laurel, Miss.; Verrett, Lloyd J., Lake Charles, La.; Wade, Patrick, Franklin, Tenn.; Warren, Richard M., Eugene, Ore.; Weagle, Cyril H., Jr., Columbus, O.; Weseli, Roger W., Cincinnati, O.; Wilson, Ronald H., Gaithersburg, Md.

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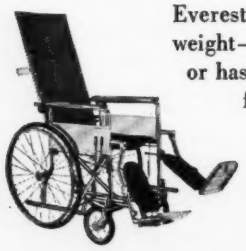
"I knew we shouldn't let Aunt Phoebe buy one in her lightweight E&J chair."

E J



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Seven Ohio Hospitals Start Local Needs Survey

Seven Dayton, O., area hospitals are participating in a survey of local hospital needs. The survey is being conducted by John R. McGibony, M.D., professor of medical and hospital administration, and director, program in hospital administration, Graduate School of Public Health, University of Pittsburgh.

Three-fold purpose of the survey is to determine whether additional hospital facilities are needed in the area, and if so, what and where they should be and whether present facilities should be expanded or new ones constructed, or both.

The survey was prompted by almost simultaneous requests, to the Dayton area Chamber of Commerce from five of the hospitals, for major fund-raising campaigns.

A technical fact-finding committee, containing representatives of each participating hospital, will furnish basic data and assist Dr. McGibony and his associates. In engaging in the survey, the hospitals agreed to accept the recommendations evolved from the findings.

Rural Area Hospitals Recommended at Meeting

Area hospitals, based on accessibility to a scattered population, are one way of bringing better medical care to rural people, according to F. J. L. Blasingame, M.D., Chicago, general manager, American Medical Association.

Speaking at the AMA-sponsored national conference on rural health, held in Jackson, Miss., in March, Dr. Blasingame said that such hospitals would be of 100 to 200 beds. These would be large enough to bring special medical talents nearer to the places where they are needed, he noted, thus assuring the coming farm generation the same quality of medical care that is available in cities.

Dr. Blasingame recommended that area hospitals be located on the basis of needs and anticipated growth. These hospitals would make it economically feasible for highly-qualified specialists to move to the country, he pointed out.

They would also play an important role in making the population health-conscious, he added.

An excellent job has been done in establishing clinics and 10-to-25-bed hospitals in smaller towns, Dr. Blasingame said, and magnificent hospitals and teaching centers have been built in large cities. The need in the future, he concluded, will be for an intermediate facility, well-equipped and well-staffed, so that rural people will have the quality of medical care they need and deserve.

Speaking at the same meeting, F. S. Crockett, M.D., Lafayette, Ind., chairman, AMA Council on Rural Health, suggested that greater acceptance of prepaid medical and hospital insurance in rural areas would be a specific way to obtain better health. Individual memberships, paid on a three-month basis, seem to be working well in some states, he said.

Heart Association Names New Medical Director

George E. Wakerlin, M.D., formerly professor and head, department of physiology, University of Illinois College of Medicine, Chicago, became medical director of the American Heart Association on April 1.

A member of the university staff since 1937, Dr. Wakerlin had previously served the heart association as vice-chairman of its scientific council and as a member of several committees.

Passano Foundation Award Winner Named

George W. Corner, M.D., Rockefeller Institute for Medical Research, has been selected as the 1958 recipient of the $5,000 Passano Foundation award.

Presentation, will be made June 25, during the meeting of the American Medical Association in San Francisco.

Dr. Corner was chosen for the award in recognition of his research in mammalian anatomy and physiology and human reproduction.

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Moves up with bed backrest!

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PERSONALLY SPEAKING

(Continued from page 76)

Mr. Logue is a laboratory and x-ray technician, Covington County Hospital, Collins, Miss.

William J. Derevlany—has been appointed assistant administrator, Waterbury (Conn.) Hospital. He was formerly with Jamaica (N. Y.) Hospital.

Paul Lipscomb—has been named acting administrator, Alhambra (Calif.) Community Hospital, succeeding the late **Ben H. Chamberlain, M.D.**

POSITION OPEN FOR CONSULTING MEDICAL RECORD LIBRARIAN AND MEDICAL RECORD TECHNICIAN
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1. Grayzel, H. G., and Schapiro, S.: Western Journal of Surgery, Obstetrics and Gynecology, Oct. 1956.

Robert G. McComas—has been appointed administrative assistant, King's Highway Hospital, Brooklyn, N. Y. He was formerly with the National Foundation for Infantile Paralysis, and Columbia-Presbyterian Medical Center, New York City.

Jack L. Moore—has been appointed administrator, Santa Rosa County Hospital, Milton, Fla., succeeding **Allen Leary.** Mr. Moore was formerly at Adams Hospital, Panama City, Fla.

Thomas J. Paden—formerly director, Memorial Hospital of Bedford County, Everett, Pa., has been named administrator, Citizens General Hospital, New Kensington, Pa. He replaces **Thomas B. Fitzpatrick,** who will become a research associate at the University of Michigan, Ann Arbor.

William M. Pierce — has resigned as executive director, American Association of Hospital Accountants, to become assistant director, Jewish Hospital, Louisville, Ky.

Appointed to succeed Mr. Pierce as director of the accountants' association is **Hugh N. Brown,** former assistant administrator, Greene Memorial Hospital, Xenia, Ohio.

Donald M. Rosenberger—has been appointed director, United Hospitals of Newark, N.J. Included in the new unit will be the Hospital for Crippled Children, Newark Eye and Ear Infirmary, and Presbyterian and Babies Hospitals.

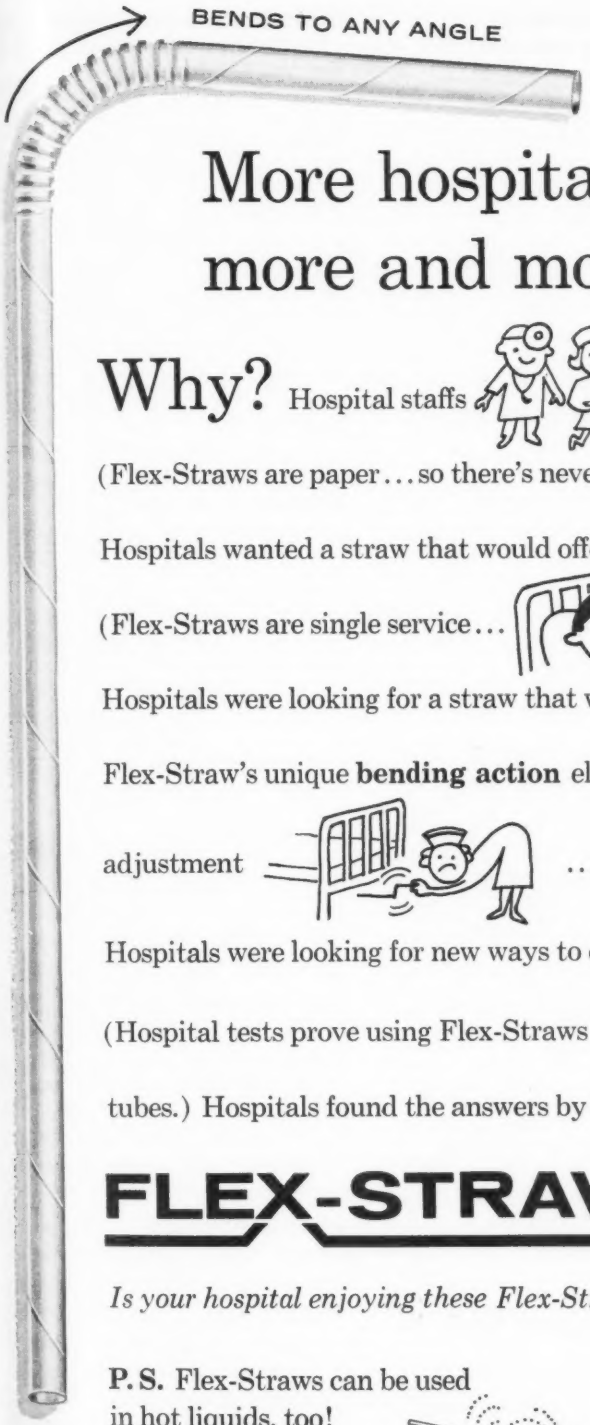
Mr. Rosenberger was previously director, Maine Medical Center, Portland.

Charles L. Showalter—has succeeded **Norman L. Losh** as administrator, Memorial Hospital, Charleston, W. Va. Mr. Showalter was previously assistant administrator in a Toledo, Ohio, hospital.

Mr. Losh is now administrator, Children's Hospital, Denver.

Mrs. Emilia S. Todd—has been named administrator, Little Company of Mary Hospital, Evergreen Park, Ill. She had been assistant administrator since 1953.

(Continued on page 140)



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Why? Hospital staffs wanted a straw that was **safe**

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Hospitals wanted a straw that would offer their patients added **cleanliness**

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Hospitals were looking for a straw that was **convenient** and **efficient**.

Flex-Straw's unique **bending action** eliminates lost motion in patient bed adjustment ...and Flex-Straws are **disposable** too.

Hospitals were looking for new ways to **economize**

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PHYSICAL THERAPISTS: (a) Chief. Southwest. 200-bed hospital; charge of geriatric unit. (b) Chief. California. 175-bed hospital expanding to 300 beds. Good future. $6,000, start. (c) Chief. Southwest. Specialized hospital for convalescent children. $6,000. (d) Chief. South. 100-bed hospital in large city. Comprehensive rehabilitation program for crippled children. $5,400. (e) Middle West. 250-bed hospital, two in department. All modern equipment. $5,700.

MEDICAL RECORD LIBRARIANS: (a) California. 250-bed hospital affiliated with university. (b) East. 100-bed hospital near New York City. (c) Chief. South. 225-bed hospital, four in department. Near Washington, D. C. (d) Chief. Middle West. 300-bed hospital. Two registered assistants plus other clerical help. $5,000 to start. (e) Chief. 300-bed hospital. Organize and develop records to meet needs of expanding teaching program. To $6,000.

DIETITIANS: (a) Chief. East. 175-bed hospital, two well-qualified assistants. $6,000. (b) Therapeutic. South. 125-bed hospital. $4,800 plus maintenance. (c) Chief. South. 200-bed hospital in large city. $6,600. (d) Therapeutic. Middle West. 125-bed hospital. Supervise special diets, manage kitchen, and do buying. $4,800. (e) Food Service Director. Man. Prefer degree in food management. South. 500-bed hospital. $10,000.

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application—a postcard will do. ALL NEGOTIATIONS STRICTLY CONFIDENTIAL.

PERSONALLY SPEAKING

(Continued from page 138)

Robert E. Wallace—has become superintendent, Abilene (Tex.) State Hospital. Previously he was superintendent, Dixon (Ill.) State School.

VA Appointments

Hardy A. Kemp, M.D.—has been appointed director of professional services, VA Hospital, Portland, Ore. He was previously director of graduate studies and graduate school affiliated hospitals, Baylor University College of Medicine, Houston, Tex.

Blanton E. Russell, M.D.—has been named manager, VA Hospital, Omaha.

Raymond F. Smith, M.D., succeeds Dr. Russell as manager, VA Hospital, Cincinnati, O.

Horace D. Smith, M.D., has become manager, VA University Drive Hospital, Pittsburgh, Pa.

New Officers

Officers of the Iowa Hospital Association, elected at the group's recent annual convention, are:

James A. Anderson, superintendent, Lutheran Hospital, Fort Dodge, president; **Thomas E. Frey,** administrator, Allen Memorial Hospital, Waterloo, president-elect; **James L. Dack,** administrator, Methodist Hospital, Sioux City, first vice-president; **Paul H. Keiser,** administrator, Burlington Hospital, treasurer. **Lloyd W. Coe,** Des Moines, is executive secretary.

Deaths

Dorothy L. Ashton, M.D.—70, director, department of gynecology, Woman's Hospital of Philadelphia, died March 20. She was associate professor of gynecology, Woman's Medical College of Pennsylvania, Philadelphia.

Ben H. Chamberlain, M.D.—77, administrator, Alhambra (Calif.) Community Hospital for the past three years, died March 23. He had practiced medicine in Alhambra for 34 years.

Henry F. Ullrich, M.D.—54, clinical professor of orthopedic surgery, University Hospital, Baltimore, died March 24. He was a staff member of 12 Baltimore hospitals, and an associate professor, University of Maryland School of Medicine, Baltimore.

M. Grace Watson, R.N.—61, chief, division of nursing, Washington State Health Department, died March 18.

Horatio C. Wood, Jr., M.D.—84, emeritus professor of pharmacology and therapeutics, University of Pennsylvania School of Medicine, Philadelphia, died March 31.

He was editor of the *United States Dispensatory* from 1918 to 1943. Dr. Wood had served as chairman, Committee of Revision of the United States Pharmacopoeia, and as vice-president, United States Pharmacopoeial Convention.

A word to the wise...
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Look for gold handles for easy identification!
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TRADE TOPICS . . .

Field sales representatives of Hyland Laboratories are shown during the recent 10-day sales meeting held at the company's Los Angeles headquarters. Seated, in foreground, are (l. to r.): James F. McGill, eastern sales manager; Frank C. Inman, general sales manager, and Raymond V. Rossi, western sales manager. Sales representatives, seated (l. to r.) are: Bob M. Hendon, John J. Burns, B. J. Blankenship, Stuart Swersie, John J. O'Brien, James A. O'Neill, Richard J. Minor, Albert H. Berni, Lewis D. Hage, Donald L. Jones, and Frank Stewart. Standing (l. to r.): William Marquis, Frank J. Galloy, William W. Moore, Henry N. Colter, S. J. Hanrahan, James V. Kelly, Fred Lundgren, Thomas Bellew, and Edwin P. Lewis.

New Division Director Named At Eaton Laboratories

Rolland J. Main, Ph.D., has been named director of the new scientific information division, Eaton Laboratories.

The new division will collect, catalogue and correlate all published and unpublished information on the company's products, as well as service Eaton's research and medical departments, and physicians.

Dr. Main has been with Eaton since 1945, first as medical editor, later as advertising director.

Raymond L. Scott has joined the new division as chief of the documentation section, the firm announced. He was formerly assistant to the director of scientific information services, Wyeth Laboratories.

Philco Corp. Appoints Marketing V-P

Henry E. Bowes has been appointed vice-president in charge of marketing by Philco Corp.

Mr. Bowes will direct all marketing of Philco consumer products in the U. S. He joined Philco in 1936 as a member of the corporation's auto radio division.

Philco has also announced two appointments in its appliance service division.

Al Tagnon has been named field service manager, and Donald McKay is the new product service manager of air-conditioning and electric kitchens.

Johnson & Johnson Gives Nursing Scholarship

Ruth E. Roney, nursing student at the University of Wisconsin, Madison, has been awarded the 1958 Johnson & Johnson Fellowship by the Nurses Educational Funds, Inc. The $1,000 annual fellowship will enable her to continue full-time study in nursing education and administration.

Miss Roney is the first recipient of the company's fellowship. The Fund is an independent corporation associated with the National League for Nursing.

Edin Co. Merges With Epsco, Inc.

Edin Co., Inc. has announced a merger with Epsco, Inc., Boston. Edin will operate as a division of Epsco., Inc., manufacturing medical and industrial instrumentation. Its operation will continue at its present location, 207 Main St., Worcester, Mass.

Murray W. Edinburg has been elected to the Epsco board of directors and will be vice-president of Epsco and general manager of the Edin Division.

General Bandages Moves To New Suburban Plant

General Bandages, Inc. has moved from 531 Plymouth Court, Chicago, to a newly constructed plant at 8300 Lehigh Ave., Morton Grove, Ill.

Dr. Volwiler Named Chairman Of Abbott Board

Ernest H. Volwiler, Ph.D., president and general manager of Abbott Laboratories since 1950, has been elected chairman of the board of directors.

George R. Cain, formerly executive vice-president, succeeds Dr. Volwiler as president and general manager, and Edward A. Ravenscroft, formerly financial vice-president, now is executive vice-president.

Dr. Volwiler assumes the post which had been vacant since January, when James F. Stiles, Jr., took early retirement to accept a position as assistant to the U. S. Secretary of the Treasury, and national director of the U. S. Savings Bonds Division.

Burroughs Corp. Names New President

Ray R. Eppert has been named to succeed John S. Coleman as president, Burroughs Corp. Mr. Eppert has been executive vice-president since 1951, and a member of the board since 1948.

(Continued on next page)

Shampaine Establishes New Field Service Organization

A new, nationwide field service organization with divisional headquarters in Los Angeles, St. Louis, and New Rochelle, N. Y., has been established by Shampaine Industries.

The new organization consolidates the maintenance services of the nine member companies of the firm. The service organization will handle major field service duties for the member companies' customers.

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All inquiries are strictly confidential.

Royal Metal Mfg. Co. Opens New Chicago Showrooms

Royal Metal Manufacturing Co. has opened new showrooms and sales offices in the Merchandise Mart, Chicago. Previous Chicago address of the firm was 175 N. Michigan Ave.

The move was occasioned by recent consolidation of the company's executive offices, and by the need for increased display facilities.

Sterilon Begins Marketing Its Own Drainage Tubes

Sterilon Corp. has begun its own distribution of the 100-R and 100-L disposable drainage tubes which it previously produced for another distributor. The move was made, according to the company, in an effort to continue making the tubes available to hospitals at the regular price.

Squibb Elected Member Of 100-Year Group

E. R. Squibb & Sons has been elected to membership in The Hundred Year Association of New York.

The firm, founded in 1858 by Edward Robinson Squibb, M.D., is one of 330 member firms in New York City.

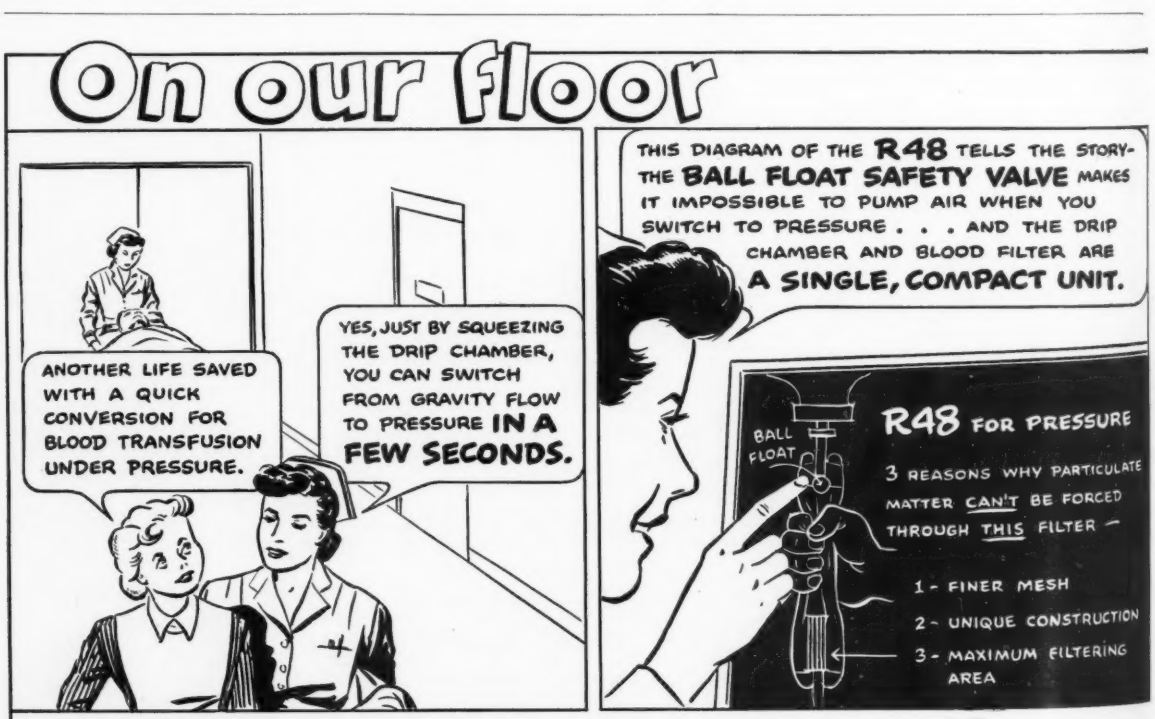
Searle Forms Chemical Marketing Subsidiary

G. D. Searle & Co. has announced the formation of Searle Chemicals, Inc., as a chemical marketing subsidiary. Headquarters will be Searle Parkway, Skokie, Ill., with an eastern office at 280 Madison Ave., New York City.

John G. Searle, president of the parent firm, is chairman of the board, and Dr. Irving V. Sollins is president of the new firm.

News Briefs

Percy M. Wilde—has been appointed to the newly created position of special representative to hospitals and colleges of medicine for Roche Laboratories, division of Hoffmann-La Roche Inc., to serve in Houston, Tex. Mr. Wilde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R48 FOR PRESSURE
3 REASONS WHY PARTICULATE MATTER CAN'T BE FORCED THROUGH THIS FILTER —
1 - FINER MESH
2 - UNIQUE CONSTRUCTION
3 - MAXIMUM FILTERING AREA

BAXTER LABORATORIES, INC. **Morton Grove, Illinois**

had been division sales manager in the Pacific Northwest.

* * *

Professional Surplus Co., Inc.—has moved its headquarters to 435 W. 19th St., Manhattan, N. Y., from its former quarters in Brooklyn.

* * *

John J. Martin—has been named assistant to E. L. Zimmermann, director of sales for the Norwich Pharmacal Co. Previously, Mr. Martin was with Batten, Barton, Durstine & Osborne.

* * *

J. P. Russell, Jr.—has been named divisional sales manager for the Southwestern division, Will Ross, Inc. His headquarters will be in Dallas, Tex. He was formerly Atlanta representative for the firm.

* * *

Hugh A. Miller, Jr., M.D.—has joined the medical staff of Ames Co., Inc. He will supervise clinical research and assist in the origination and evaluation of new diagnostic and therapeutic agents.

* * *

Abbott Laboratories—has moved its eastern division sales office from Cincinnati to the Abbott Philadelphia branch headquarters at 650 E. Erie Ave. Eastern division sales manager is Harold C. Clauson.

* * *

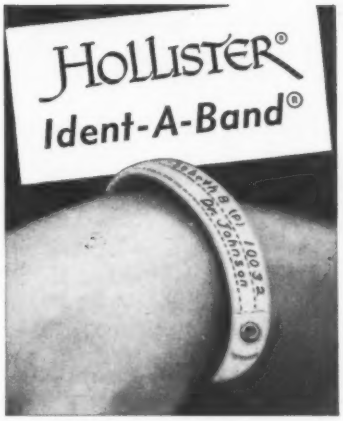
Joseph M. Krizan, Jr.—has been appointed assistant advertising manager, Eaton Laboratories. He will be responsible for advertising to the medical profession and drug trade. Before joining Eaton, Mr. Krizan was merchandising manager, Davis & Geck, Inc.

* * *

John B. Dunne—has been appointed assistant sales manager for the Bomgardner Mfg. Co. He was formerly sales manager, medical and hospital department, Globe Industries, Inc.

Lloyd C. Bender has been named to the newly created post of field sales manager for Sherman Laboratories.

Mr. Bender was formerly field sales manager for Armour Laboratories and prior to that was district manager for the E. L. Patch Co.



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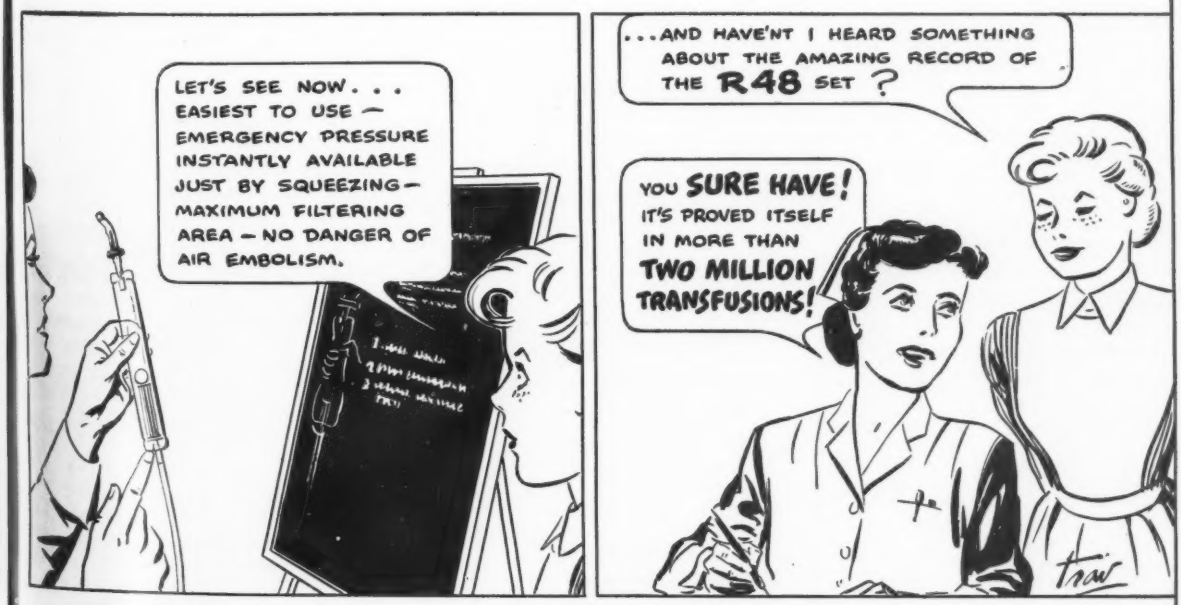
LET'S SEE NOW. . . EASIEST TO USE — EMERGENCY PRESSURE INSTANTLY AVAILABLE JUST BY SQUEEZING — MAXIMUM FILTERING AREA — NO DANGER OF AIR EMBOLISM.
. . . AND HAVE'NT I HEARD SOMETHING ABOUT THE AMAZING RECORD OF THE R48 SET ?
YOU SURE HAVE! IT'S PROVED ITSELF IN MORE THAN TWO MILLION TRANSFUSIONS!

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An Insurance *refund?*

THAT'S RIGHT. And LEGGE may help you toward one, too.

Accident frequency is the barometer by which casualty insurance premiums are measured. High accident rate—high premium rate. Chief culprit, 9 times out of 10, is slip-fall mishaps.

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Many LEGGE clients report not merely insurance reductions—but *voluntary refunds!* Why not plan a Safety Program around LEGGE? Start now by clipping the coupon. It may help you save thousands of dollars.

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Xavier University to Offer Administration Programs

Xavier University, Cincinnati, O., will inaugurate four programs in hospital administration this summer.

Designed to provide training in hospital administration and management at all levels, the courses of study include a certificate program, a degree program, institutes, and inservice training.

To receive a certificate, the student must complete 15 hours of study. Workshops will be offered, as part of the program, in various areas of organization and management. A workshop on hospital personnel administration will be held August 4-16, and one on financial management, August 19-30.

Under the degree program, the student will receive a Master of Business Administration degree upon completion of 12 credit hours in hospital administration and 12 hours in general business administration survey courses. First classes for degree students will convene June 16.

Special short-term insitutes are planned in areas such as credit collections, plant maintenance, laundry operation, safety, and union relations.

James F. Martin, assistant professor of business administration at Xavier, has been named director of the programs.

Chicago Director Cited For Distinguished Service

John N. Hatfield, director, Passavant Memorial Hospital, Chicago, has been selected to receive the 1958 Distinguished Service Award of the American Hospital Association.

The award, given for outstanding leadership in hospital administration, will be presented during the association's annual convention in August in Chicago.

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146. Oxygen therapy
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148. Parking lot plans

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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